

HIT Policy Committee
Draft Transcript
July 10, 2012

Presentation

Operator

All lines are now bridged, Ms. Deering.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much, operator. Good morning, this is Mary Jo Deering in the Office of the National Coordinator for Health IT. Welcome to the 38th meeting of the HIT Policy Committee. It a public meeting and there will be an opportunity for public comments at the end. I've also asked the members who are of the committee to identify themselves when speaking for the transcript. I'll begin by taking the roll? Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Dr. Madhulika Agarwal? She is present, but just stepped out. David Bates?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Neil Calman?

Neil Calman – The Institute for Family Health – President and Co-founder

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Richard Chapman? Patrick Conway? Art Davidson?

Arthur Davidson – Denver Public Health Department

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Connie Delaney?

Connie White Delaney – University of Minnesota/School of Nursing – Dean

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Paul Egerman?

Paul Egerman – Businessman/Entrepreneur

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Judy Faulkner?

Judy Faulkner – EPIC Systems – Founder

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Tom Greig? Gayle Harrell?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Charles Kennedy?

Charles Kennedy, MD – Accountable Care Solutions, Aetna – CEO

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

Here by phone.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Frank Nemec? Marc Probst?

Marc Probst – Intermountain Healthcare

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Josh Sharfstein?

Joshua M. Sharfstein – Maryland Department of Health & Mental Hygiene

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Latanya Sweeney? Rob Tagalicod?

Robert Tagalicod – Centers for Medicare & Medicaid Services

Here by phone.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you. Scott White? Okay, thank you very much. I'll turn it back over to you, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good, thank you Mary Jo and welcome everyone to the meeting. Today's meeting is going to be...so Farzad is caught in traffic so he'll be here in a few minutes. Pardon me?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

He's on his bike.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

On his bike, hmm, okay. So, today is going to be largely one of updates and this is in preparation a little bit of a more relaxed setting than next month when we are going to be talking about some of the recommendations or the preliminary recommendations going forward from associated with Meaningful Use Stage 3. So, today we'll hear the long awaited update from CMS having to do with the attestation and the barriers for a lot of report from the RECs. We'll hear from Larry Wolf about some of the long-term care and post-acute care initiatives going on, as you know that they're not covered in Meaningful Use, but we do want to incorporate them in the overall plan. Then after lunch we'll hear some brief reports about a couple of hearings that we had in the past month, one on clinical quality and the other on patient generated data and we'll finish with an update from ONC on various matters by Jodi and Lygeia.

Any questions on the agenda? If not, let me entertain a motion to approve the minutes that you received from last month.

M

So moved.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And second? Okay, any other amendments or edits? Okay, all in favor?

M/F

Aye.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And opposed or abstained? Thank you, and let me ask Deven to give a little announcement about a hearing that's going to happen tomorrow.

Deven McGraw – Center for Democracy & Technology – Director

Yes, for those of you who are traveling and want to stay in town for an extra day or if you're here and you are interested in the issue of trusted identity of providers in cyberspace we invite you to join us tomorrow for a hearing from 9:00 to 3:00 at the DuPont Hotel where we will be discussing these issues, it's a joint hearing of the Tiger Team and the Privacy and Security Working Group of the Health IT Standards Committee. So, we're going to do the technical and the policy essentially at the same time, but we will each report to our own respective committees on recommendations that surface from what we hear tomorrow. So, again, all are invited, a very important topic. Any questions, let me know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, and it will be? Where is it going to be?

Deven McGraw – Center for Democracy & Technology – Director

Oh, the DuPont Hotel.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, great.

Deven McGraw – Center for Democracy & Technology – Director

Nine to three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. So, we've timed it just perfectly for the arrival of Dr. Mostashari and time for your updates and comments.

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

Well, I'll just be brief; I have just two things to mention. The first is to acknowledge all the people who submitted comments in response to our request for information on the governance rule which closed on June 29th. We received in total 140 parsley submissions that commented on a variety of issues that we had asked about. We had clearly asked a lot of questions. This was an initial request for information and it was kind of far ranging. We asked questions frankly about a very expansive range of issues and many of those issues we were fortunate to solicit comments. So, we're in the process now of putting the...figuring out what people liked, what they didn't like, what were some of the misconceptions perhaps about what we had proposed and to bring it together back to this committee.

The second thing I wanted to mention was just our debt of gratitude to Josh Seidman, who is going to be leaving ONC, joining the alumni association for ONC as we call it. He has been really a tireless and really focusing on how we can improve health and healthcare for the patient in all of the work of the Meaningful Use Workgroup and all of the activities that he has helped support at ONC and with this FACA and we owe him a great debt of gratitude. Thank you, Josh.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's it, okay, yeah there were 66 questions, to be exact, that we responded to. Okay, and thanks to our first panels on the Meaningful Use update and we appreciate your forbearance when we postponed it from last month when we had to answer the 66 questions that Farzad set out for us. But, we welcome both Rob Anthony and Dawn Heisey-Grove to give us an update on the status of Meaningful Use, some of the barriers that you've run into in terms of the RECs and how people are doing. This is an anxiously awaited report so we'll be listening with great interest.

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

The barriers we've learned about.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Learned about, learned about, learned about, yes...go ahead.

Robert Anthony – Centers for Medicare & Medicaid Services

So, thank you, I'm going to start here and talk a little bit about status and then talk about actually some of the barriers that CMS specifically has learned about in doing some of its own wave surveys which you'll find neatly dovetail with the same type of things that the RECs have found as well and then I'll will turn it over to my colleague at ONC to talk a little bit more in depth about that.

W

...

Robert Anthony – Centers for Medicare & Medicaid Services

Better? Okay. Registration and payment data for the month, this is the month of May. We do have some estimate numbers at the end here. We had 10,000 registrants in the month of May, brings us to almost 250,000 registrants for the program to date. As you can see, we're pretty much looking about pace with previous months, a little slower perhaps on the Medicaid side but I think when we look at overall and when we look at paid, we're looking at about pace.

This is a breakdown just of the Medicare Meaningful Use payments, at this point in May there were close to \$168 million dollars in payments made which brings us over 2.8 billion for Medicare incentive payments, these are of course all for Meaningful Use. We've talked about this before a little bit of the breakdown of individual specialties, obviously family practice and internal medicine always dominate this list but we do have a wide selection of specialties that are represented here in Meaningful Use and in fact you'll see afterwards 57% of EPs who are receiving incentive payments through Medicare are specialists at this point, non-primary care.

The other category, as I always like to remind people is a rather significant category and it's representative of several things, it's representative of folks that may be in specialties that didn't quite make this top 15 list because there was a small enough number. Also, there are a number of providers within our PECOS system, our Provider Enrollment Chain and Ownership System which is where you register your specialty but actually doesn't have a specialty indicated so all of those get bundled into the other category.

As you can see there has been, in May in particular, a little bit of a drop off in just eligible professional payments, the overall payments were higher or on par in May because we paid the Medicare Advantage Organization EPs. There are a smaller number of eligible professionals who have come in. This is pretty much matches what we saw last year where the curve for the year was relatively slow and then towards the end of the year we really saw it take off. I think that we'll probably see something relatively similar with this year, obviously the people who are coming back for the second year we won't even see them until January, February, March of next year, but people who are coming in new seem to have their 90 days somewhere in the middle of the year and tend to really pick up steam in October, November and going forward.

These are the Medicare Advantage Organizations that were paid. At this point I believe it is 9 Medicare Advantage Organizations, a little over 11,000 eligible professionals for a total of almost 190 million. We do make all of those payments at once so you'll see this happen year over year where in April or May after all of the EP payments have been calculated we do the Medicare Advantage Organization payments.

Medicaid is also on track. There were 4,160 eligible professionals paid in May, obviously the bulk of those are for adopt, implement, upgrade, but we do see...you can see here 182 for Meaningful Use in May. We also have another 101 hospitals for AIU and 12 hospitals on the Medicaid side for Meaningful Use. The total for Medicaid was a little over 200 million, bringing them close to 2.7 billion total and as you can see they're tracking pretty closely, again, we see a little bit of a dip here in May, but the total number of eligible professionals is about on track with what we've been seeing. So, the total for the official total through the end of May brings us to 5.7 billion and over 113,000 providers paid so far for the program.

We did...I'm not sure why I have a decimal on that one, but there was a request to look at some of the percentages, that's a little bit hard to breakdown so I will try to explain this pie chart a little bit. There are on the eligible hospital side a total universe of 5011 eligible hospitals that large chunk of the pie on the right, which should say 73.08% rather than .7308, is representative of the percentage of total hospitals that have actually registered for the program, so 73% of hospitals have registered for the program, that slice is then broken out on the right and you can see that out of those 73% that have registered that's a total of 3,662 hospitals registered, 2,438 unique hospitals have been paid or about 48% of the total of all eligible hospitals which leaves that small gap who have registered and have not yet been paid. This is receiving a payment under both programs or either program.

This was a little harder to breakdown for EPs because there is both the Medicare and Medicaid side so I've broken it down by registered and paid. There is a total universe of 521,600 total EPs who can participate in the program, we've got about 163,000 that are registered for Medicare or a little over 31% are registered for Medicare. A little over 81,000 or 15% are registered for Medicaid. So, we've got close to about 50% of all EPs currently registered for the program. There is a gap between registered and paid and that's a little bit of what we're going to talk about later because we started looking at that gap and trying to figure out what got people to register but didn't quite get them to attest and paid.

So, again, this is a representative of the total universe, a little over 521,000 total EPs, a little over 58,000 Medicare EPs have been paid through May, that's about 11% of the total of eligible professionals, about, a little over 40,000 Medicaid EPs, so almost 8% of the total universe of EPs. But, all together it's 48% of all hospitals that have received a payment for either Meaningful Use or adopt, implement, upgrade, 15% or 1 out of every 7 Medicare EPs are Meaningful Users. The total universe of Medicare EPs is about 382,000, in case anybody is curious, it does mean that about 1 out of every 5, we're at about 20% of all EPs have received a payment, which means that 1 out of every 5 are either Meaningful Users or they've made that financial commitment to an EHR. And, as I mentioned, 57% of Medicare EPs that are receiving incentives are specialists we're not able to breakdown that way on the Medicaid side, I know that some people had asked that question, but we don't have that type of a breakdown on Medicaid EPs.

There also was more of a request to take a look at, I think, according to individual specialties, what percentage of dentists and we don't actually have a breakdown of the total estimate of numbers that is individuals by specialty but we can say that over half of the EPs that are receiving incentives are specialists.

This is what June is looking like. This is obviously not official but we do expect a report in about a week, a week and a half. It looks like close to 9000 providers total out of which a little of over 440 of those are hospital payments which would bring us up to...actually it would bring us higher than this, it'll bring us, I think, to about 122,000 total providers paid. So, we're looking at almost 400 million in payments in May which will bring us pretty close to \$6 billion dollars in incentive payments disbursed through the program through the end of June.

Just looking at our attestation data and I will go through this relatively quickly because I think there are not going to be too terribly many surprises here. It is very similar to what we have been seeing. We're really hoping that now that we're getting towards the very tail end of the last who are being processed from 2011 that we will be able to look at this and say this is what 2011 Meaningful Use looks like. We do have 74,000 EPs who have attested here and close to 1400 hospitals represented.

There are the folks who asked how many are unsuccessful and what do we know from attestation and the people who failed that indicate what the barriers are and I think I've pointed out before that we really don't know a great deal about what the barriers through attestation are from actual attestation because very few people have been unsuccessful in their attestation. No hospital has attested unsuccessfully. Only 274 out of over 74,000 EPs have attested unsuccessfully and out of those 274, 170 resubmitted and...sources to take a look at what the barriers to attestation are and we'll talk a little bit about that and obviously, Dawn will talk a little bit about what the RECs are seeing.

But, overall, all the thresholds are well above what the measurements were although there are obviously always people who are hovering at the line. We're not seeing a real change in the most popular menu objectives or the least popular menu objectives. EPs and hospital scoring is relatively the same and specialists are scoring the same high marks as primary care providers are, although there is obviously a difference in the menu items that they choose and the objectives that they exclude.

So, these are the most popular menu objectives, it's not a terrible surprise, immunization registry as an EP, you have to submit to one public health objective and the vast majority of EPs don't have access to submit to a syndromic surveillance database so most of them are choosing immunization registry. Drug formulary, patient lists, eligible hospitals this has remained unchanged, its advance directives, drug formulary and incorporating clinical lab tests results.

These two are the unchanged, the least popular menu objectives, transitions of care for all providers. We've talked a little bit I think in the past about some of the confusion surrounding transitions of care, providing patient reminders for EPs, which I'm not sure if we discussed before, initially it was a little bit of a puzzle to us until we started talking to some ambulatory practices and realized that a lot of these EPs actually use a practice management system and are using their type of patient reminder through that and may not necessarily have incorporated at all into their EHR yet.

And then eligible hospitals, syndromic surveillance, it's again the availability of that as a reporting database. So, no huge changes here, you're not going to see any major fluctuations, so there's not really a whole lot to highlight. We are breaking down the reporting objectives or the recording objectives, rather. This is the problem list, medication list, demographics, vital signs and so on. We previously had these all bundled together and indicated they were all over 90%, but as you can see certain of them are very close to 100.

We're seeing the same type of values overall, a little bit lower perhaps on send reminders to patients, it's dropped a few percentage points, but I don't think that that is anything significant, we're still seeing a performance that is well above the measurement of 10%. This again, when people are actually engaging in these things, they are doing it very well. When they are providing an eCopy of health information they well exceed the measure of who they provide it to. Many people of course are claiming that exclusion because they're not being asked for an eCopy of health information, that's what the exclusion is dependent upon.

The vast majority are providing well above the 50% for office visit summaries. These again are the care coordination and we've talked a little bit about these in the past, not many people are doing them, they are deferring them for menu choices when they are doing them. They are performing very high on these objectives and then of course these are the public reporting objectives and exclusions are fairly wide ranging here and can account for any number of reasons they might not be able to submit working with the different HL7, not having the correct transport method, so on and so forth. Hospital scores again are very similar so I won't go through all of these, but they are available for people to take a look at.

So, when we look at that difference between the nearly 50% of providers who have registered for the program and the 20% who have actually been paid for the program, we wanted to take a look at and discover what is it that gets people to one but they're not able to get over the second hurdle, what is it that is the barrier? So, we periodically do wave surveys, we do these almost quarterly. We target a pretty wide range of eligible professional types and we do concentrate primarily on eligible professional types although we also will do some interviewing of Chief Medical Information Officers or CIOs at hospitals, but it has been primarily concentrated on the EP side and the data that we're taking from here was really centered around eligible professionals and we went back to folks who had registered but hadn't attested out of our database and specifically began asking them questions about what were the particular hurdles.

And this represents what we discovered as sort of the primary barriers for both adopt, implement, upgrade and for Meaningful Use. I think that in slightly different terminology you're probably going to see the exact same things that are represented on the REC data. So these are sort of the six that we had lumped them into categories, knowledge gaps, technical support, vendor support, information that was particular about specialties, return on investment and productivity concerns, and then finally state on-boarding, although I should point out that at the time that we had done a number of these surveys there were fewer states that were on-boarded and of course that represented a much larger barrier for adopt, implement, upgrade payments for people now that we have 45 states on-board and we expect that the rest will be on-board by the end of 2012 and that is less of a concern as a barrier.

I should note, actually going back to this that these obviously are not representative statistically of the different barriers that were indicated. If we were to make this pie chart representational, knowledge gaps would take up by far the largest amount of this pie and when we looked at some of the key issues in regards to knowledge gaps they were very wide ranging. What we discovered was we had folks who ran the entire gamut of things, people who had registered for the program because they got communication saying you should register for the program and really did not know what the next steps were after that.

So, we had people who wanted very basic knowledge about eligibility criteria, people who we discovered did not have knowledge about existing resources that were available, people who had gotten involved because they had heard about the incentive payments but then discovered that they needed a lot more information about what the actual requirements of Meaningful Use were. There was definitely a gap, although I think that with some of the information we've put out since we've closed it, on clinical quality measure reporting, people not understanding whether there was a bench mark to hit. And then finally there was a definite knowledge gap concerning payment adjustments, penalties. There was both a gap in terms of people not understanding that there were payment adjustments that would be applicable in 2015 for Medicare and running all the way up to folks who were trying to really understand the details about payment adjustments.

So, this was very wide ranging and we used a lot of the information that we got from knowledge gaps to design a lot of the interventions that we come up with to design resources. So, we're really putting a lot more energy into basic level education resources. There are, on our website now, a very basic introduction for both Medicare and Medicaid that walks people through, a little less jargonizing, a little bit more illustration dependent rather than as heavily texted as some of our early materials were.

We really focused some of this by audience segment so you'll notice that some of the education resources really are geared towards, especially on the basic side, office and practice managers. Some of them are geared particularly towards small practices, but we continue to work towards developing some materials that are specific to each of those audiences and that's really one thing that we discovered when we talked to people is that there really was a feeling that there wasn't a breakdown of material that was targeted towards their particular situation.

The other thing that we've really been working on this year and continue to work on and obviously a key part of our communication strategy as we move forward is partner association outreach and I should say that's partner association and partner organization and I'll talk about some of the organization that we do some other things with, but in particular partner associations, different provider associations that we've worked with to reach some of these audiences that we can tailor information to and as part of an overall webinar strategy to...I don't know how many people subscribe to our...but we do try to make sure that everybody is aware of the webinars that we're doing with different associations through our...but we have done any number of things with organizations like Paycom. We have some things that will be upcoming with the national health initiative.

There are a variety of partners that we're working with in addition to our own national provider calls which we've used some of the survey information that we've gotten here to inform what the actual provider call subject matter will be rather than just an EHR incentive call, we've tried to tailor specifically to questions that we had gotten about eligibility, specifically about registration and attestation. We did one recently with ONC about certification and response to some of the other things that we saw.

Another key issue that emerged was on the idea of...and this is sort of for lack of a better term because it's sort of catch-all, but technical support. There was definitely a knowledge gap about certified products themselves, that there were products specifically certified for this program, existed on the very basic end, but there were certainly, for folks who were even more well informed about the program a lack of knowledge about what constituted a certified EHR, how the certification process worked, how you would go about the selection of that. And again, we used some of that information to inform not only the national provider call we did recently with ONC but some materials that we're trying to develop in concert with ONC specifically about certified EHRs.

But there was also emerged this idea about technical support for product selection, that there was a real feeling that there was a lack of information specifically in relation to this program about what people should look for in an EHR, which EHR they should buy. You'll see when we talk a little bit about specialty information there was the perennial question that we get from specialty practices regarding well what EHR is right for my X practice, plug in whatever that specialty is.

So, as I said we have worked with ONC to do some national provider calls. We are expanding the certification section on CMS's website and pointing to ONC's website. We are working on a basic certification guide in concert with ONC and then of course, I think Dawn will talk probably a little bit more about what REC is doing via assistance for product selection, but we're trying within our resources to make it more explicit that RECs are there to provide that type of support for people.

There did emerge a theme about a lack of vendor support. There were certainly...there was a question of a lack of vendor support for Meaningful Use issues, some providers identifying vendors who weren't necessarily either knowledgeable about the Meaningful Use issues or were not providing enough in depth information for them on Meaningful Use issues. But, then there was also an indication of a lack of support for basic technical issues, customizing that EHR, adapting that EHR to their particular workflow.

One of the biggest complaints that we have heard is about the on-boarding delay for software implementation and I'm actually...I sort of put REC and ONC efforts here because I didn't want to steal Dawn's thunder as she is going to talk more about this than I really will, but it did emerge as a theme for us in our wave surveys as well.

As, I said specialty information, there was definitely a perceived gap about how Meaningful Use works with particular specialties, how particular objectives would be adapted to particular specialty workflows. We have certainly talked with ONC about creating some REC education materials for that and there are some existing REC education materials for those things. We are again working with partner associations to do a number of webinars so that we can customize some of the information that we generally put out.

I think that as we move into Stage 2 talking about the hardship exceptions for certain providers is going to play a key part in this and then we are certainly looking, as I said, to break down more of our materials by particular specialty. It's a little bit harder on the strictly Meaningful Use side because Meaningful Use is Meaningful Use as far as what meeting that measure is, however, we're working closely with ONC to see how we can build some of the REC library of materials to talk a little bit more about answering some of those questions like "what EHR do I choose for my cardiology practice?"

One of the biggest things that emerged was, and this was especially true I should say among physicians, was a question of return on investment and productivity issues, the identification of a lack of financial resources to implement this, a concern about the loss of revenue that would occur during implementation, how long that implementation period would be, the loss of staff time to that implementation or to the use of EHRs in general and a general theme of the sort of perception of burden of healthcare reform in general, it was not incidental to the EHR incentive programs, it was a discussion about the implementation of ICD-10 and some of the other things that are happening.

So, we have talked a little bit and I'm not actually sure whether you have this in yours or not, but we do have...there are case studies that are available through RECs that talk specifically about this. This is where I think as we move forward; we really want to work with partner association because this type of outreach in some ways does have to be specifically tailored to some physicians because it can be particular to a type of workflow or specialty.

We have worked...and this is where partner organizations come into play...we have worked with organizations like Medscape because as we have talked to physicians that peer to peer discussion of where ROI happens really seems to have the most effect on convincing people that it can make sense for them and Medscape is particularly good at reaching physicians.

But in general I think that we know and we are working towards more education outreach and resources available about healthcare reform in general, and how some of these initiatives play together. So, I think as we move forward you'll see a little bit more of that especially as we look at things like ICD-10.

Part of what we wanted to do in terms of outreach to providers was again along that peer to peer side and have them talk specifically about the EHR incentive programs and to that end we worked with a number of providers at HIMSS to do some recording of testimonials, they are available on our website and I actually wanted to show you some snippets of some of those testimonials of people who were specifically talking to this ROI and productivity issue. So, if I can ask you to key that? And I apologize to the folks on the web, but this won't be live streamed. Please stand by.

Well in the absence of actual sound, what we have are a couple of physicians who speak specifically to the question of return on investment and specifically talking about how the 44,000 total Medicare incentive amount they discovered was pretty close to what their cost was for implementation and then talked in general about what benefits they've seen as they transitioned as far as being able to cover more patients, being able to track things a little bit more closely.

These are actually what we were playing, it's just about a 4 minute snippet, but there is a variety of these that are available on our YouTube channel if you go to our website and you go to the education resources page there are some links to each of these videos and will talk a little bit more about the EHR incentive programs, it's too bad, it had a great guitar intro and fantastic testimony. Well with that I will turn it over to Dawn to talk a little bit more about what the in depth REC showed.

Dawn Heisey-Grove, MPH – Office of the National Coordinator

Okay, I'm going to be talking about the Regional Extension Center reported practice level challenges to achieving Meaningful Use and we're trying to shift towards using the word challenges because we've been told that barriers is kind of perceived as a wall that nobody can get around and we believe very strongly that these are, you know, just kind of very small little bumps in the road. So, with that said, I will try to remember to use the word "challenges" whenever possible and I have a challenge in getting the screen to pop to the next slide. Am I hitting the right button? There we go.

So, we started collecting from the RECs back in November, challenges at the site level in the CRM which is the database where we captured this information. The data is captured at the practice level and then within a practice you can have multiple sites or a single site and then you have the provider level information. And so the RECs are entering all of these barriers at the site level and that's important to remember as we go through this.

They are all entering the data in slightly different ways. So, when you look at this data it's not really scientifically based, it's observational. Some of the RECs are entering a barrier or an issue for every single site that they have and some of that is just to say this site is on track and it's moving towards Meaningful Use and we don't have anything else to say about it. And then others actually have a barrier or challenge that they're trying to get around. Others are only creating an issue for the practices that are actually stuck or have a challenge that they're trying to resolve. We also have four RECs now that are sending in external files to us and that data is actually incorporated into slides that I'm going to be showing you.

What we've done is categorize the information into really five primary categories. The fifth one that's not on this slide is that on track category, it does not have any secondary or tertiary categories into it. And within each of the primary categories, which are practice issues, vendor issues, the attestation process issues and Meaningful Use measures, there are secondary categories and we're working on developing tertiary categories for some of the larger buckets and some of the larger tertiary categories will even have fourth level categories that we can drill down into.

And the goal of producing these secondary, tertiary and fourth level categories is so that we can then bucket solutions and present them in a concise way on the HITRC, which is the web portal that the RECs use to find tools and solutions, and ultimately for the best of the best solutions put those on healthit.gov. I have definitions for all of these primary, secondary and tertiary categories if anybody is interested you can let me know and I'll send you those categories.

The other thing that we just started doing recently is to identify the challenges that have been resolved and this is important because just because an issue has been reported to us, if it's six months old, we want to know if that's still a problem or if it's actually been resolved and they've moved on. And it's important to know, you know, of the very large bucket that we now have, because we have 15,000 reported issues, are those, you know, are there still active problems and do we really need to focus on coming up with solutions for those active problems or have those been resolved. And if a particular set of problems such as attestation process have been resolved then we don't need to focus on developing solutions for those.

So, we have two ways that we can identify resolved issues, the first is at the site level and that's just simply if the REC goes in and marks that an issue is completed then it's considered to be resolved. The other way is if a second issue is created that indicates the practice is now on track then the first issue that they created, you know "I'm having problems selecting a vendor" would no longer be considered a problem because the practice is now or the site is now on track.

The second way that we can resolve issues is at the provider level and this is based on...because if you think about it, one provider in a practice may have an attestation process problem, I'm not focusing on CMS it's just the easiest thing to come up with an example for, but they could have one but there are five providers at that site. We don't want to have to say that five of those providers are still having that problem if four of them have actually attested to Meaningful Use or gotten their AIU payments. So, we are also resolving the issues at the provider level and you'll see that in the additional slides that I'm going to show.

We have two ways of presenting the data here. What is displayed in these rows of data are the secondary categories for each of them that we're looking at and these are the overall numbers of providers impacted for each of these secondary categories, and this is important because, you know, Meaningful Use measures has over 3,000, slightly over 3,000 providers that have been impacted but 10 or 11% of those have been resolved. Now, if we're trying to figure out what are the trends coming up and moving towards, you know, that we really need to focus on in the up in coming problems, looking at the overall numbers is not as useful as looking at what's happening right now.

So, the very last column on the right-hand side actually shows you the new reports for this month. So, while Meaningful Use measures may be specifically the...maybe number one overall, we can see that provider engagement is actually the top issue for this past month. And this data is through June 4th. So, its, you know, it's a little bit old but it's still pretty consistent with what we've been seeing.

As Rob had mentioned, vendor selection is still a big issue but what's nice to see is that last month vendor selection overall was ranked number one and this month it's now number three and so it's definitely going on and we see that 21% of the providers who had reported this as an issue have now resolved that. So, they've picked their vendor, that's fantastic news, they're coming up with ways to find that. That means that either the solutions that we've been posting and providing are actually being used or they are just finding their way on their own.

The other thing that Rob had mentioned was the practice financial issues which is number ten and that's consistent with two months of data and you'll see that 15% of those have been resolved and to your point about what we're doing within the REC, one of the CoPs is actually developing a return on investment tool that a provider can go in or an REC can go in for the provider and show them, based on some of their practice data, what kind of return on investment they might get. So, that might be something useful.

In terms of how some of these other categories might stack up to what the CMS group has, the provider issue training, which is not really on here, so, okay, I'm going to just move on. Vendor upgrades actually is one of the more interesting ones. So, in the CMS data they had mentioned that vendor upgrades was a problem and it had been when we first started looking at this. What's really nice to know is that this has been consistently, over the last few months that we've been watching these trends, dropping over time. And so, it's no longer the highest priority and it was definitely up there when we first starting looking at that data, 14% of all of the providers who have reported this as a problem have now resolved this and I think that's good.

So, this is really I think the best way to look at these data, is to look at the trends for each month, because this shows you what are the up and coming issues and what has been resolved so that we know, you know, where people are finding solutions and how they're solving their problems. And, at the time that we created this slide we had only done the resolution calculations for one previous month, so I think that as we start showing the RECs that we're actually looking at the resolved status that we'll be resolving more of those and we'll see these just naturally start going up as we train them how to use the data.

So, you'll see that the biggest movement here for the top ten new issues overall are the vendor technical issues which I think reflects some of what Rob had mentioned as well and these are...technical issues in our category are really things like they have to buy more hardware or they don't which hardware to purchase, or they can't get their interface up right, so that's really where our technical issues are being seen.

You can see that the other thing in here is the vendor selection is still within the top 10 overall, although it's, you know, it's not in the top 5, so that's something up. And the Medicaid program not up yet, while it is up in the top 5, I think that that should be going down pretty quickly as Rob had mentioned most of the states are coming up.

Practice staff training, I think that is the one that buckets nicely with the knowledge gaps that Rob had mentioned as a problem and so that is also in the top 10. Meaningful Use measure specific issues, so, these are the measure specific issues that providers and RECs have identified as problems. And what I will tell you about these is the numbers will never add up to the same numbers that I have mentioned as the 15,000, almost 16,000 barriers that we have seen and the, you know, 45,000 providers that have been impacted and the reason is, is that within any one issue the REC staff that are entering these can select multiple measures as problems. So, you may have one issue that may have five measures reported as a problem.

But, consistently since we've been looking at this data the clinical summary core 13 has been at the top of the list and that has not really changed, I think it switched one month with the security review, but pretty much those are at the top consistently. The little arrow is a little bit shifted from where it should be, but number 7, which is, remarkably enough menu, item number 7 which is medication reconciliation jumped 6 spots from last month to this month, so, it's an up and coming problem. It wasn't on the top 10 last month and this month 405 providers are now reporting that as a new issue to them. The other things that have been up and coming are eCopy, which I think was reflected in some of the attestation data that Rob showed, that just seemed to get louder.

Then the other way that we have the ability to pars out the data is in how the providers are trying...at what stage in EHR adoption they're getting to, whether they're trying to get to AIU because those providers would have a very different set of problems than whether they would have...whether they're trying to get to Meaningful Use, well actually that's a different slide, sorry I apologize. This slide is just a new measure specific issues that have been reported this month.

And so, to clinical summaries, one of the things that we're working on and coming up solutions are we've come up with several different WebEx's and tools for the providers to use and I think that hopefully as those tools get out into the marketplace and out into the RECs and start being used those should become very useful. There have been all sorts of different documents and WebEx's and training for the clinical summaries.

This is the Meaningful Use section, so these are just providers who have done their AIU and they're just trying to reach Meaningful Use and you can see that the top 10 is slightly different. There are more vendor issues on here than the overall top 10, but they're getting resolved pretty nicely. You can see that the vendor reports that are slow or not available, 17% of those issues have been resolved. So, there is some movement, but delays in implementation and installation, which is different from waiting for your upgrade, that is an up and coming issue, it was number 12 last month and this month it's number 6. So, that something we need to watch and work with.

One of the things that we're doing with the RECs...we have a group of providers, I'm sorry a group of EHR vendors that we work with and we are presenting to them each month a list of their barriers, sorry challenges by state with the number of practices impacted and asking them to come up with the list of the solutions that they would typically provide to practices who are facing those problems and if, you know, they have a whole bunch of practices that are waiting for upgrades or they say their reports are not slow, what kind of solutions would they propose to those practices and we're going to be feeding those solutions from the vendors back to the RECs and they can work with the providers.

And, as appropriate, I think that the plan is to hopefully funnel those vendor provided solutions onto the healthit.gov page, but that is a little bit further out. So, we're definitely working with the vendors directly, giving them these data and saying, what can you guys do to help so that we don't keep seeing these in the top 10?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I have a question, when you say new reports this month, so a new report would show up in there. If it is persistent the following month where do they show up or do they get essentially dropped?

Dawn Heisey-Grove, MPH – Office of the National Coordinator

That will be in the overall numbers, so this right here is the overall numbers and so the total number of, if I said new reports I apologize, but this is the total providers impacted overall. The column on the right, the far right, the reports this month, that is the number of new.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So you are saying you are still having trouble let's say with the vendor or provider engagement they will still show up in column two, the total providers impacted?

Dawn Heisey-Grove, MPH – Office of the National Coordinator

Yes, that's column three, yes, that's where they will show up. So, we'll never lose that count and that's why the overall number is so important, but in terms of seeing up and coming trends, the new reports I think are where you want to look.

These are just the new reports. So the top...and the reason why I show this in addition to this are because the top 10 new reports are different than the overall numbers. Here you can see in the top 10 new reports vendor delays and implementation and installation has moved from number 9 in the previous month to number 3 in top in new reports for the month. Staff training at the practice level is also a problem as well provider engagement and these are things that we're working with the RECs to come up with solutions for because they've all faced these problems in the past and they probably have lots of tools just making sure that they share those tools and among themselves is probably very, very important.

So, overall what we're seeing...and the pie chart on the left is the unresolved issues. So, if an issue has been resolved, it's not represented in this pie chart and you can see overwhelmingly the problem, overwhelmingly, almost 50% of the issues that have been reported by RECs are practice level issues, these are problems with staffing, these are problems with administrative issues, provider engagement which we have seen has been number 1 consistently or in the top 10 consistently. The practice issues are the problem.

Vendor issues, which we hear a lot about, are 29% of the problems. So, you know, it's a bigger issue or a bigger block or chunk of our data that is saying the providers, the practice manager, the office managers all of those people they are having problems within their practice in trying to get to Meaningful Use. And then the Meaningful Use measures, the specific problems associated with the measures is 11%. Attestation process is 12%, but, as Rob mentioned, I think that will be going down pretty quickly.

And you can see resolved issues...the rate of resolution for these, 24% of the attestation process has been resolved, fantastic, we'll expect that to increase a lot over the next few months. And nice enough 10% of the Meaningful Use measures have been resolved and about 13% of the other two. On track resolved usually means that those practices or sites have met Meaningful Use and that's great.

So, within the practice level issues, it's pretty much split evenly among the different categories although provider engagement is leading the group there and so we just need to find more ways to get the providers engaged in the process overall and you can...the chart on the right is a little bit difficult to see, but if you wanted to really get your magnifying glass out you can see how things are being resolved at which stage. And again, the data is only through June 4th so that little June bar doesn't mean much.

Vendor issues, this is pretty much split again throughout the group, but delays in implementation and installation is the biggest issue with 25% of that pie, of the unresolved vendor issues followed closely with the upgrades. But, as we saw earlier upgrades are getting resolved and moving down the top 10, so I think that upgrades is less of an issue and just getting the product installed maybe a bigger problem.

Attestation process, this is not a real surprise, but again, we hope to see that these will be resolved fairly quickly at this point. The other, the Medicare and the Medicaid as a quick definition, those are where people, probably individual providers are having problems with getting their attestation issues, they don't understand, they need to get a PECOS site, ID or something like that and so it's more of a technical issue.

Then speaking to...we haven't broken the data down specifically by specialty or provider specialty and I don't know that our data is organized to do that, but one of the things that we can look at is the practice type and you can see here that based on the practice type the barriers that are in the top 5 are different and I don't think that's surprising to anybody in this room, but it also speaks to the need, as Robert said, for specialist to have specific tools that address these specific problems. And in one of these slides I think what we'll see is these are the measure specific issues broken down by practice site and you can see that critical access hospitals, which is that third column on the right, has medication reconciliation jump up four spots in the last month and other under-served settings has menu 8, which is the summary of care record jumped 8 spots this month. And so those are some of the things we need to focus on, ePrescribing last month jumped up a lot for community health centers.

So each group is facing different sets of problems and I think that we need to start looking at the solutions that we have and make sure that they target these special groups, and we are definitely doing that within the RECs focusing on critical access hospitals and what their problems are and with these other groups we're working with HRSA for the community health centers. So, I think that there is definitely some room to help providers using this data as our bench mark to what we prioritize. And, that's all I've got.

Robert Anthony – Centers for Medicare & Medicaid Services

The technical gurus assured me that they have fixed the problem; I do want to say that we are beginning to use that type of data as well to help inform how we're pulling together materials for partner associations and also in our educational materials. It helps greatly to know for example the objectives that are really facing...

M

Interestingly enough a cost of about \$44,000 per physician, FTE to implement the EMR in its first year, but we saw an approximately \$63,000 dollar savings due to efficiencies and improvements in various aspects of the cost of delivering care. So, for us it was a re-enforcing principle to say if you invest in the technology to that amount, you can expect, if you work together, if you strive to achieve appropriate use which when the Meaningful Use requirements came out actually looked very, very close to the same expectations that were in the Meaningful Use regulations.

So, for us it was a small process of adjusting the way we were using the EMR to make sure that all of those elements counted, but it was easy to see the business benefits which re-enforced the quality benefits and fulfilled our hope in the early days that this was not only the right thing to do for quality but that it actually might improve our practice's financial health.

It helped us with care coordination, it helped up implement a patient portal so we could communicate with our patients, it helped us with some of the interfaces we needed to be able to make sure information was flowing and again it happened to align quite nicely with what turned out to be some of the core menu and quality measure components of the Meaningful Use regulations.

M

I think it was a practice decision, we all decided that we wanted to be...we liked be cutting edge, we liked being on the forefront. We recognized that an EHR is where medicine is headed. We think that the project is a good idea. I think that we want to be part of the movement towards electronic medical records as a way of capturing data of making sure that we're more efficient, making sure that we're adhering to quality indicators and it just made sense. After having made the decision to adopt electronic health records we were sort of proud of the fact that we could use those records and participate in the program.

M

It really rewarded us well. I'm in an economy where we had 34 primary care doctors shutter their doors in the last 8 years, 8 of those were actual bankruptcies and the number of emergency room physician beds or I'm sorry the number of emergency room beds increased by 100% and the number of emergency room physicians increased by 50%. So, basically more and more people were going to high cost centers to get their healthcare at a later stage of their illness and yet while that was all going on, our practice was able to grow from one physician and one computer to 14 providers, 4 locations, about 50 employees, over 80 computers working in a centralized status center and about 27,000 patients.

Probably the most rewarding part of it for me was knowing that we were making our practice, our community better for our patients. In order to maintain relevancy, we had to get into this century...technology the way other industries have and in doing so we've created patients that are healthier, an environment that's saver, a workplace that's more efficient so the staff are happier, it's easier to retain staff.

Robert Anthony – Centers for Medicare & Medicaid Services

I told you it had a great guitar part. Thank you everybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you very much. Comments from the group? Marc?

Marc Overhage – Siemens Healthcare

Yeah, there's a lot of good data here, so thank you very much and actually the two views is very helpful as well. The one thing that would be really helpful and maybe it's just me, and if it is we can do it off line, it would be nice to know how successful we are with Meaningful Use. So, Rob, when you present the numbers it's got all the AIU numbers built into it and obviously you have the detail, it would be nice just to have it pulled out and look at Meaningful Use and how successful is it being, you know, in the numbers of practices or the physicians, EPs and the number of hospitals that are on the up take? Because, again, I think that ought to reflect into Stage 2 and 3 Meaningful Use because that's what we defining not AIU as much and it would just be a good number for us to see.

And then I don't know how we do it...the other thought I had as you were going through it is as we project...and that was a great comment by the first physician, about the \$63,000 dollar per physician benefit that they were getting. I'm wondering though if that's typical or how we might project...you know, how do these costs aggregate over time and benefits, and, you know, eventually the incentive money goes away, it's a penalty, but hopefully we get everyone to Meaningful Use so that won't be an issue. But, what are the lingering, longer-term costs as we project into the future, you know, just the expenses associated with managing this, but this is pretty encouraging and really good information. But most for me was the Meaningful Use, if we could just look at that somehow.

Robert Anthony – Centers for Medicare & Medicaid Services

Yeah, that information we recognize especially as we move into the second year. The first year was easy Medicaid was AIU and Meaningful Use was Medicare and as we're moving to the second year we don't have that. We do have that data there but we can definitely pull that out as a separate slide just to show out of the folks that are there which percentage are MU.

Marc Overhage – Siemens Healthcare

It just might help us as we continue to look at 2 and 3.

Robert Anthony – Centers for Medicare & Medicaid Services

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Gayle, please?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Thank you very much. This is fantastic I really, really was delighted to see the identification of the different barriers, I think that is a very significant thing that we need to address and certainly our RECs are such a key component of assisting EPs in doing that.

My concern is that unfortunately a lot of the RECs are not helping address situations for specialists and there seems to be a lot of the questions and a lot of the difficulties is down in the specialty areas and as you develop the tools for those specific specialties, I know Rob you mentioned that you are starting to develop those and working together with the RECs, it's important that that gets down there to the specialty levels because that's who I hear mostly from are on the specialty levels, that they are having...whether it's vendor selection or meeting Meaningful Use, what criteria is appropriate for them or, you know, what are their work flow issues and what fits into their practice is really difficult for them. So, the more tools we can give...although the legislation doesn't provide for specialty outreach in the RECs, it's more geared toward the small primary care practices. I think that is where the need is to a very large degree and the more tools out there for them on your website or other means is very, very important.

The other question I really have is on the RECs themselves and maybe Dawn this is more for you, and the more tools we can give across the board to our RECs is very important, but there seems to be some inconsistency across the nation and state on the different RECs, some more successful than others. Are you keeping track of that? Because I hear, you know, around the state of Florida, I hear from other states and some...there's different levels of RECs out there. So do you want to comment a little bit on that and perhaps let us know, you know, how you're dealing with that and give us a better feel? In some areas it seems to be better than others.

Dawn Heisey-Grove, MPH – Office of the National Coordinator

So, I guess I'll try to briefly comment. This month the RECs are having their regional meetings and one of the really nice things about these meetings is that they're taking the people, the RECs that are doing really, really well and highlighting what they're doing well and how they're doing it, and all of the other RECs in that region get to hear how they're doing it and learn from those groups and they're building connections, and it's basically an entire two-day meeting of learning sessions.

And there are tracks on tactics and how to get to Meaningful Use and those things, as well as what each REC is doing to resolve barriers and where they have a really great tool. I went to the one in Baltimore last week and somebody presented this amazing vendor selection tool and everybody in the room was just fascinated with it and so these meetings are the perfect way to leverage the RECs that are doing well and help the RECs that maybe struggling in other areas.

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

Before there are any questions I just want to clarify that there is absolutely nothing to eat or drink at these meetings.

Josh Seidman – Office of the National Coordinator

I think this also adds, just to build on that, you know, I think, we have 62 REC and when they were created, you know, in some cases they were organizations that in affect were already RECs. I mean, they were already providing these kinds of services, they had some sophisticated staff and so forth and in some parts of the country there was just nothing and they had to be created out of nothing and I think that, you know, obviously created some challenges, but I think part of what Dawn's saying is that, you know, what we've tried to do is create these communities and in addition to the regional meetings and the annual meetings where they're getting this very intense, you know, two-day workshops, there is also this ongoing work.

So, there is a Meaningful Use community practice and a vendor selection management community practice, and a dozen other communities of practice, and these communities of practice really are helping to build communities around best practices and how to do this. So, clearly there are some RECs that, you know, started from a lower point and the idea is to bring them all up to the same quality.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Follow-up on a question, yes, thank you very much. A follow-up along that line, what are we doing in terms of measurement to know, because at the end of the day these are tax payer dollars that are funding this entire thing and we have a fiduciary responsibility to make sure that we measure outcomes and that's what Meaningful Use is, we need a Meaningful Use for RECs as well to make sure that we're measuring along the way and what are we doing to safeguard those dollars for those that are perhaps not meeting the mark and how are we addressing that?

Josh Seidman – Office of the National Coordinator

Well, the REC was specifically built as sort of a pay for performance program in its own right, so there are three...almost all of the...there is very little money up front for the RECs and almost all of the money is for meeting certain milestones. So, milestone one is for getting providers signed up. Milestone 2 is for getting them live on an EHR and milestone 3 is for actually getting them to Meaningful Use and not just AIU if they're Medicaid providers.

So, you know, there is a strong incentive for them to support all their providers in actually reaching Meaningful Use and I think, you know, that was...obviously there are a whole series of things that lead you to there as Dawn's data shows, but clearly by having at least these outcomes of getting to Meaningful Use as something that they need to do in order to collect their full grant dollars that really does help to reward people who are getting to where they are supposed to be getting the providers.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

And, I assume those dollars of course depend on achieving certain benchmarks but as areas perhaps are not getting all to what they should be getting, what's our back up plan? How are you encouraging? What are you doing to make sure that a struggling REC gets there and that the dollars are being well spent?

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

We actually...these kinds of data that we showed in terms of being able to drill down to the practice level, the barriers they are facing, the number of solutions they have, the number of practices in each category that are getting to different milestones, the amount of monitoring that we're doing on the extension center program is in some ways a model for what can be done using modern technology. So, we have a cloud based customer relations management that is tied to our Grant's Management Office and our folks have gotten some federal awards for how nicely tightly integrated those are. So, that really lets us identify which extension centers are doing great things in different areas and through these regional meetings and through our staff helping to share those good practices.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments or questions? Charles?

Charles Kennedy, MD – Accountable Care Solutions, Aetna – CEO

I also found this information very insightful. One question I had is, as you know there is significant linkages between the Meaningful Use Program and the ACO Federal Program both in terms of, I think it's 50% or so of the ACO providers need to be Meaningful Users and the measures, performance measures overlap substantially. Will this process give us any insight over time as to how the physicians are able to use the Meaningful Use process to become ACO enabled? Will you give us any insight as to any problems that they might be having in that way?

Robert Anthony – Centers for Medicare & Medicaid Services

Yeah, you know, I think we're looking at the Meaningful Use data in a variety of ways and that's one of the way in which we'll look at it going forward. Now, obviously, it's not as simple as looking at attestation and saying well this is the measure that everybody's hitting, that's something that we're going to see more of a trend over time. One of the things we're also looking at is, you know, versus particular physicians do we see reductions in certain areas because of certain objectives. We want to see what affect Meaningful Use actually has.

So, what I can say right now with confidence is that we're looking at it. What time it will take to actually get some idea of, you know, what that impact is I'm not certain at this point, but I think we're thinking in the same terms.

Josh Seidman – Office of the National Coordinator

Yeah, and I'll just, this is Josh again, and I'll just add that one of the things that we're also interested in is not necessarily, well we're interested in the ACOs, but regarding patient centered medical homes because obviously that is sort of linked in some ways. We have worked very closely with NCQA on aligning the programs, the NCQA recommendation program for patient centered medical homes and Meaningful Use, and we are actually now working with them at looking at data. So, we actually recently signed a data agreement with them so that we are actually going to be looking at the recognized providers and looking at their Meaningful Use data and starting to do some analysis to try to get some data insight into the kinds of things that you're asking about. Did you want to say anything?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments or questions? I can't resist making a comment about one of the comments the first doctor in the video made, which is that Meaningful Use happened to pay off. I want to acknowledge the incredible public process that hundreds of volunteers on the Workgroups and the people who participated thousands of hours, the Workgroups and the HIT Policy Committee, the HIT Standards Committee, the public who commented on the proposed and the comment, the RFCs, and the folks at CMS and ONC that really over time have made this an incredible both process and output.

I think the Meaningful Use Program has been a success by the numbers that were just presented and more deliberate than just happened to pay off for the doctor that said the first comment. But at any rate, so thank you for your presentation today to show where we are, the challenges we're still meeting now and for the incredible work that has gone on to get us to this point. So, thanks very much.

So, next, we're going to hear from Larry Wolf who is going to talk about a different project that's not currently covered by Meaningful Use, just by statute, but there's still ongoing work to try to connect all the dots between the providers in the front line whether they are eligible providers, eligible professionals in hospitals, but throughout the whole continuum. So, we're going to hear about long-term care and post-acute care. Thanks, Larry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, let's see if I can get all the gadgets working here. It's great to be talking about this. I know it's been an on and off again topic over the last several years actually and I feel like there has been a real shift in the conversation from we need to get focused on the eligible providers, eligible hospitals because we need to get them their incentive payments to let's look really broadly at what is the healthcare system in our country and how do we make sure that the technology we've put in place really meets the needs of the whole of our population. Maybe a quick backup, and this is done in collaboration with John Derr, who is on the Standards Committee. So, a variation on these slides was presented to standards a couple weeks ago.

So, I guess there are a few main points here. This is about patient centered care and about coordinated care and in many ways historically there has been this notion of it's about long-term care and long-term care was then flipped into nursing home care and so this became really a very small piece of what we're actually talking about here.

So, currently we're identifying two big areas what's called post-acute care, so this is specifically individuals coming out of an acute care hospital where they've had something that's happened to them, some major event and they need time to heal and recuperate, rehab programs, and then there are people who need longer term care because they have some level of disability, some level of chronic needs. And these two groups of providers often interweave the kinds of services they offer and sometimes it's hard to actually see what's going on because the two populations have been blended in a lot of the reporting and a lot of the regulations.

One thing that's really important about these care settings is regardless of the specific care setting, there is a real emphasis on interdisciplinary teams. So, where a lot of the discussion around Meaningful Use is what physicians do and is very physician centric, these are care settings that have varying amounts of physician involvement. At the high end physicians are there every day. At the low end, it's maybe a once a month or once every few months check in with physicians. So, a lot of the care is delivered by other clinical staff not physicians. And truly in terms of the chronic needs a lot of it's done by the individuals themselves and their support network which has a lot of non-professionals involved.

So, while the perception has been that these sites were not included partly because of their inability to participate, I think that there has been a shift in that over the last several years as well. So, there is really an increase in what's happening in these different care settings. And among these providers there is a real sense of actually being aligned with national priorities for quality healthcare.

So, I pulled out a piece of the Federal Health IT Strategic Plan that specifically identifies this care segment long-term post-acute care and also talks about behavioral health and other settings and so my materials don't speak to behavioral health or those other settings, but I think that there is a consistency really of the major issues to all of the settings.

There is a group that has been very key in terms of pulling together the various players in this segment. The long-term post-acute care health IT collaborative, it's been going for several years now; it's kind of a self-started effort to look to address all the issues of getting to the table and then moving forward with an agenda. There have been annual summits. There has been great participation from the federal agencies as well and a series of road maps.

So, interestingly the most recent road map seems to align very well with a lot of things we talk about here. So, a big emphasis on care coordination, quality and process improvement, business imperative, in particular...and I want to stop here on the business imperative piece because I think it's a hinge point for a lot of things. It hinges on the issue of coordination of care. These providers only exist because other providers refer patients to them for care and as we're seeing them move towards ACOs, big upper case ACOs and lower case ACOs, patient centered medical homes. If you want to be part of the team providing care you have to be able to share information with the rest of the team. And so the need to have good information exchange is a business imperative beyond any specific ROI. You don't get to engage if you can't be part of sharing information.

A real awareness of the importance of consumer and caregiver engagement here, as well as work force issues that these are environments where on the one hand they often have a very high turnover rate amongst staff, they also have staff that have been doing this for decades and a real personal commitment to the kinds of patients that are being cared for.

So, I have to have a few graphics in here. I can't do a presentation without trying to tell a story. So, this is the story of being person centered and people go about trying to live our lives and so living our lives there is an emphasis on looking to stay well, preventing problems and managing long-term things and then something happens and so there is an acute event and there is all of the world of diagnosis and interventions, treatments to sort of address the acuteness, and then there is what I'm calling post-acute which is addressing the healing recovery, rehabilitation phase.

And so, the intention here is to make this look that it's a seamless flow. Of course, in real life it's never so simple there's a lot of silos that happen and not just among those big arrows, certainly within even pieces of those arrows there are issues for better coordination and people's lives are not so simple. As we age and as genetic propensities develop our health gets more hard to keep going, its more multi-conditions are going on, you know, so maybe I'm managing, you know, my diabetes really well but my lung issues flare-up and so I maybe have an acute flare-up of one thing and cycle around with that, but the other things seem to stay managed.

And so sort of switching from what goes on into some of the variety of settings here, one of the things that's really a big piece to telling the story here is there are so many care settings and it's not just that they sort of exist as varieties in the world, but individuals touch in with very many of these and often the problems of communication are because the hand offs seem to go deeper than just the immediate care setting to the current care setting.

It's not unusual for someone to show up at the emergency department and so you get information, a lot of information from their ED encounter, but you don't know what happened in the week or two before that ED event. You don't know what their health maintenance issues are and so they're going to show up and we know, oh, there's been this flare up of some kind and now we know the plan for that, but what about everything else that's happening and often those are places where there is really poor communication and issues like behavior health that maybe are irrelevant during a short acute stay when you're recovering from surgery and you're mostly drugged up on the, you know, on the pain, the legal pain-killers and now you're in here trying to deal with the rest of your life issues and suddenly psychosis is an issue or a long-standing addiction has been triggered because now you've been on pain-killers and you have an overwhelming desire to get back on them beyond the actual pain. So, the need to know more about the whole of the person is a really big thing and our focus on single point hand offs while it's absolutely essential really is not sufficient.

There's also been an emergence, I would say, really in people's thinking over the last year or so that having the history, so care summary CCD is a great thing, I don't want to minimize that and the power of that, but it really is a look backwards. And there has been an emergence of the recognition that we really need a care plan. We need to know what the plan is going forward and it needs to be a broad care plan that recognizes the complexity of the condition someone has and the fact that there are multiple agents supporting that plan and it's being carried out longitudinally over time.

So, the next few slides talk about sort of how big is this space. So, approximately 1/3 of Medicare hospital discharges get some amount of care after that hospitalization. The first row of percents are where people go initially on discharge from the acute care hospital and the second row is where they go eventually. So, 61% of Medicare hospital discharges will eventually get some kind of home healthcare. The biggest initial destination is skilled nursing facilities typically as a short stay. So, this is all Medicare payments, this is short stay addressing the acute condition and then a lot of those patients go on to get home health, may go on to get outpatient rehab and then the two most acute settings, the long-term acute hospitals and inpatient rehab.

So, a year or so, I guess now, almost two years ago American Hospital Association put out a report and there is a link to it there and I think there are a couple of slides in here from that. One is looking at the variation in intensity and so this is looking at the acuity in the acute care hospital and then the setting they went onto, and it shows for the LTAC long-term acute care hospitals, inpatient rehab, skilled nursing, home health agencies. And, so the mix of patients that goes to these settings is different and this is sort of part of trying to communicate the message here that the needs of the receiver vary a lot and they vary based on what's happening.

So, typically the LTACs are paying attention to folks who are on a ventilator. Someone made the comment there is a lot of septicemia in your hospital and so we go, yeah it's true that's how they come to us. So, they have a really bad infection that is now healing, they're stable but we need to maintain them, we need to not re-infect them with something else. We need to make sure that they stay on their medications all that stuff, patients with really bad skin breakdown and then you go into the inpatient rehab and SNFs where it's much more focused on the medical problems have been addressed; now we have to focus on the rehab issues. And home health is can we make the transition, actually living at home, can you manage your medications, are there additional services you need beyond the medical services so you can be successful at home.

So, part of the hand off issues here is they also have shifts in terminology as we go from setting to setting, the focus on the kind of care that is being provided may lead to additional questions. So, you gave me the information I asked for but it's not really the information I need. Also, issues of completeness, you gave me the medication list, but not to overwork the psychiatric issues, but there were no antipsychotics on it and this person is psychotic and they've been on medication and they've been pretty well managed on their medications. Where did their medications go? So, it's those kind of gaps in the sending provider is saying what they know but their view is limited and they don't have enough of a view of the patient.

And this slide, just to give a sense of total dollars spent, this is a few years old, but, you know, proportionally it's still pretty accurate, number of individuals who have been seen in these major care settings and the amount of money that's being spent there so, not insignificant dollars.

Several of these settings have required assessments and they need to be done electronically and submitted electronically, and building on this everybody speaks a different language. Historically these assessments have been different and they've been collecting different information, and reporting it differently. There was a prototype developed, something called CARE, Continuity Assessment Record and Evaluation that is intended to be a multi-setting assessment tool that could be used in all of these settings including acute care settings and my understanding is that CMS is now looking at this as a core set of components that they can start to use as they update Regs and plunk these into the different care settings and we're seeing a little bit of that in some of the requirements for beginning this October.

I want to acknowledge the work that NQF is doing with the MAP Project that is really looking across all the care settings to develop a consistent set of measures and a quick looking at some of what those measures are. So, a piece about certified EHR technology, so we're now shifting from what's in the space of the providers to what does the Health IT look like.

So, I put this up highlighting some of the things that ONC has stated in the proposed rules for Stage 2 that identify a base EHR and the kinds of things that that is looking to address, most of which actually is spelled out in the legislation. And, I put up this notion of a micro kernel, really what's the minimum necessary? And I put this up to sort of highlight a piece that ONC has done a good job building the base so that it addresses the minimum necessary for Meaningful Use and it does that looking to do that across setting types and this is really then extending that to say, well what about providers and possibly folks who aren't even providers might extend to personal health records, might extend to private duty folks that you're bringing in to provide services for you.

So, what do they need if they're going to help to be in this ecosystem of care? So, really here it's more asking questions. So, what's the base we need to provide process and quality improvement? What do we need so that we actually have a legal record of what's been done? What's necessary to improve care coordination? How can we build on standards and interoperability, measuring and quality reporting, really looking to achieve that goal of a learning health system and focusing really on minimum?

So, I know that historically there have been problems, as soon as you say minimum, people go, oh, that's all I need to do, do the minimum and I'm done and I really hope that this is seen not in that sense but really more as a core technology piece of what do we need to do so that products across-the-board can have capabilities built into them to allow for the information exchange and good stewardship of the data when an organization or an individual has it.

So, there are some certification things in place today. So, the modular certification has been used by some of the vendors in this space to do just that to say our product can meet the criteria, maybe we had to add some things that are not particularly necessary in our space but there wasn't a big stretch and for some of the core requirements we can do that. So, there has been some of the traditional players in this space have gotten modular certification.

CCHIT really continuing to work that they did pre the ATCBs has created a comprehensive certification program for long-term and post-acute care with specific focus on nursing facilities and home health agencies but looking more broadly than that as well. Because there are requirements in those spaces to do things that are not addressed by the Meaningful Use or the modular certification.

So, thank you to the survey that is done by AHA that looks at all hospitals, so in addition to the short term hospitals that have been widely reported on that data set also includes information on long-term acute care hospitals, rehab hospitals and psychiatric hospitals. So, the big message here is that those settings do have systems but their adoption is lower than in the acute care hospitals. This is based on the 2009 survey, so it's all pre HITECH and pre Meaningful Use and it would be good to do that again. And so, there is a theme here as you'll see in the next few slides that the data is old and we really should be building in looking at these care settings as part of the routine surveys that happen in those settings.

So, this is nursing facility data it's 2004 so it's almost a decade old. The message here is that there is some automation in nursing centers even going back to 2004. And there is some more recent data on home health and hospice agencies that was collected by the National Center for Health Statistics and I think that they are actually a great resource for us to use nationally to make sure that their surveys actually are asking Health IT questions about all of the care settings that they survey so that we can get a national baseline of what's going on where not just driven by Meaningful Use.

So, I think I've said almost everything these next few slides are going to say about multiple care settings, that each go through their admit care and discharge process and individuals tend to hit many of them, eventually they wind up back in the hands of their primary care doctor and then they're back in the short term care hospital.

Care coordination is multistep. So, we tend to think about there is a single transition that happens from one setting to the next but there really has historically been a lot of effort put into making a good handoff and that it's not just a toss the patient over the wall thing, although that sometimes happens and I saw a great presentation recently that said, you know our actual health information exchange technology is the ambulance, because we put the patient in the ambulance and some information goes with them and then it shows up at the receiving end. So, hopefully that will help us all focus and we want to do more than just put the patient in the ambulance.

Also, because these settings tend to be lower tech, there is a lot of ongoing coordination during the admission. So, some of the interdisciplinary team is on site, but typically there are no labs on site. So, labs are all done off-site. Often there is an off-site pharmacy. There may be rehab services provided by another organization. So there's a lot of players involved that need to coordinate what they are doing.

So, now some of the things that are happening. So, a shout out to the work that ONC did with the state HIEs and some challenge grants that were issued a year or so ago, a little over a year ago I guess, almost two years now, Colorado, Massachusetts, Maryland and Oklahoma all got additional funds into their HIE work to specifically address how do they improve coordination of care and they're all taking a slightly different approach and we could talk about that for the next half-hour, but I don't want to stand between us and lunch too much.

The National Governance Association has done some work in this, although most of that work has stopped because of the vagaries of funding and in then some states who didn't get challenge grants were doing some good things anyway. So, Delaware, sometimes it's good to be small, has all of their acute care hospitals on-board and has some level of agreement with all of their SNFs and the other major long-term and post-acute care providers, but that might be that they've signed up for access to a portal. So the amount of information exchange here should not be overblown.

And others are looking to do some clever things with information that's already there. So, I mentioned that there are required assessments. So, the Keystone Beacon Community has taken the information in those assessments and has repackaged it into CCDs so that you can take one or multiple of these assessments and they're done periodically for patients and produce corresponding kind of care documents.

S&I Framework has a community led initiative that is specifically looking at longitudinal coordination of care and that's really where this work on what does it take to do a good care plan has been surfacing and that's building on the other work that S&I has done on transitions of care more broadly. So, this is about helping people live their lives. I think we have some time for discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Josh?

Joshua M. Sharfstein – Maryland Department of Health & Mental Hygiene

Thank you for the great presentation it's an incredibly important part of the healthcare system. I just wanted to get your thoughts about the relationship that Medicaid has with long-term care facilities and how this fits in? I think the healthcare systems incentives pre Medicare and Medicaid are pretty dysfunctional right now and there's a lot of focus on, particularly for people who are duly eligible for both programs, eliminating some of the conflicting incentives and developing a more streamlined approach for states particularly where you don't have the situation where a long-term care facility can kind of play games between Medicare and Medicaid payment and Medicare has certain incentives that may disadvantage Medicaid and Medicaid has incentives that may disadvantage Medicare. How do you think that intersects with the push toward modernization of the infrastructure here?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, without whining, I think that there's a huge concern in this space that payments are really below need and particularly around Medicaid payments. And so, there's some sense of a cross subsidy happening that the higher payments from...so it's a little bit schizophrenic, so the higher payments for Medicare are sort of helping the facilities stay afloat so it can provide services to the Medicaid folks. On the other hand, Medicaid is sort of paying room and board rate and keeping the building open, so.

Joshua M. Sharfstein – Maryland Department of Health & Mental Hygiene

Yeah, well, I mean, it depends where...that part of it certainly in all directions there are different concerns, because patients who are in long-term care facilities are less likely to get admitted to the hospital. So, if Medicaid is paying it's a savings to Medicare, but right now there are, you know, conflicting incentives. I think that as the dual eligible problem gets resolved and I think it's going to be a focus probably on some of the budget discussions, that there will be a big push, an external pressure for places to develop these kinds of systems, because I think one of the things that has fueled the or sort of taken away the incentive for more efficiency and modernization is the fact that there is all of these weird conflicting incentives out there, and as those get resolved and you see that there is really an expectation from the largest payers that there be efficient care across the inpatient and long-term care facility whereas now those incentives may not exist which are in populations. I think you'll start to see everybody's interest lineup and this will accelerate even further.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think that's a really good point. Certainly the emphasis on...the new emphasis into eligibles is looking to address this much more comprehensively. And, it's also the case that people who are in the long-term side of nursing homes, it's not uncommon for them to leave and get community-based care of some kind for while. So...

Joshua M. Sharfstein – Maryland Department of Health & Mental Hygiene

So, that will accelerate too, yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, basically there's a lot of pressure for the states to do that, but I think even our notions that nursing homes, you are there forever are not...that's no longer true regardless of whether you're there just for rehab or you're there for a longer stay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you, Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Thank you very much, yes, I couldn't agree with you more, Joshua, it's a major problem for the states because of course Medicaid is funded 50% by the states and when you live in a state like Florida and we are trying to balance our budget and a significant part of your budget with 65% of the people in nursing homes are Medicaid paid for in the state of Florida, this becomes a major issue and that care coordination you've got conflicting incentives going, but at the end of the day it's the patient that really needs to have that care coordination and without nursing homes being part of the whole endeavor it really leaves a big chunk of the healthcare of our senior citizens out of what we are trying to do with electronic health records and with making sure you have that care coordination, that component that's so essential.

I think states have a natural inclination or should have some input into this whole thing on the nursing home level in incentivizing and really assisting in doing some payment basing and maybe Medicaid needs to think, CMS needs to think about this to think about how you can do it better in nursing homes with long-term care since this is a partnership with states and federal government and states need to be on-board with this as well. And there is a whole new conversation that could take place as we move forward in looking at that and developing that. The same thing goes with behavioral health. Again, the states play a very key role. A lot of people with behavioral health issues and substance abuse issues are on Medicaid not only are they on SSI, but they're on Medicaid as well and they are huge cost drivers when it comes down to states and the number one increase in state budgets is Medicaid. So, huge issue and states need to be more involved in that whole conversation.

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

Larry, I was wondering if you could give a flavor of the kinds of data elements that might be important for the LTPAC transition that maybe have not been already represented in the transition of care data elements in Meaningful Use and certification.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I'll give a general answer and maybe I'll punt to one of...incent one of the challenge grants. So, I think structurally that the CCD does a very good job of capturing history and at this point my sense is that most of the receiving systems are not really able to do something with the granular data but they're looking to be able to receive it as a document and have a human being read it and probably initially that it will supplement the existing information that they get. So there will be paper stuff and electronic stuff and so I think it's a step in the right direction and sort of what we're doing.

The comments I hear talking to folks anecdotally is...so they're looking at what they now receive on paper, that a lot of that paper now is obviously computer generated and there is pretty good timeliness. So, it may be in the medical rules that you have, you know, weeks to do your discharge summary, but we're seeing a lot of discharge summaries arriving with the patient so that's a good thing and so, you know, we're doing well there, but there are gaps and the gaps I think are more because of the silo'd nature of healthcare, they are the medication list comes but it's not complete or there may be a disconnect, the medication list comes but it isn't indicated when the last dose was so there is some confusion and need for a phone calls to start out things like that.

A lot of times the rehab stuff doesn't get fully addressed and so if someone shows up and you need to do a sort of from scratch rehab assessment, even though more was known about their status in their prior setting.

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

I wonder if there's any data in terms of looking at readmissions and bounce backs whether there are information gaps in particular, whether it's fall risk, whether it's diet, whatever, that obviously medications clearly we know is a huge issue, but if there are other high-priority issues that are...to which the bounce back can be attributed that our information gaps then may serve as an area for us to focus a little bit more on what we're trying to accomplish.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think a really good thing to focus on, my sense is that's only now just getting addressed. So, if we look at sort of the partnership pressures people under, the post-acute providers are all being told we'll partner with you but were now going to track readmissions and so that there's a lot of tension going now to root cause analysis of why did this readmission happen, you know, and to someone's point the other day, you know, it was a surgical patient who is now having a medical management issue so they are readmitted for their medical issues or it's a patient on, you know, recovering from some medical thing but some of their chronic conditions are now flaring up. So, the anecdotal sense is that some of these are going to be complexity readmissions, that it wasn't necessarily the specific reason for the acute admission that's causing the readmission.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, Judy?

Judy Faulkner – EPIC Systems – Founder

Yes, thank you Larry, we've heard stuff that I know I've been talking to folks about for quite a while trying to figure out what happens here. One of the big problems is terminology and I know you were trying to address that to some extent there and I want to ask you, is a short-term acute care hospital the same as an acute care hospital?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, yeah, in the language I'm using here...

Judy Faulkner – EPIC Systems – Founder

They are identical?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Short-term acute care is what's traditionally called acute care or general hospital.

Judy Faulkner – EPIC Systems – Founder

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

The reason I make the distinction is the long-term acute care hospitals are licensed as acute-care hospitals.

Judy Faulkner – EPIC Systems – Founder

Oh, okay. So, then my next question is, is a long-term acute care hospital the same as long-term acute care, the same as long-term post-acute care? Are those three the same?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

No, so I need to make some shades of gray distinction in there. So, the whole space I'm talking about is long-term post-acute care, all of the different settings. It's common in the literature to see people talk about long-term care hospitals and leave off the acute and those typically are the long-term acute care hospitals are the long-term care hospitals. And, again there has been an evolution over the last couple of decades that these were originally mostly long-term psychiatric hospitals and then they started having other long-term patients, and then those patients started to be more short stay long-term. So, I didn't talk about typical lengths of stay in these settings.

Judy Faulkner – EPIC Systems – Founder

Okay, so what was the typical?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

They run around the month.

Judy Faulkner – EPIC Systems – Founder

So long-term care hospital isn't quite equal to long-term acute care hospital because a psychiatric patient might not be acute?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, typically that's right. So, there is some inherent confusion in this whole thing.

Judy Faulkner – EPIC Systems – Founder

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And then...

Judy Faulkner – EPIC Systems – Founder

And then post-acute care, but are they all post-acute care then or not?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, not necessarily. So, typically the phrase long-term care means nursing center and you could be in a nursing center for a long time because of a general decline in ability to take care of yourself at home or in some other non-institutional setting.

Judy Faulkner – EPIC Systems – Founder

And skilled nursing how does that fit into it?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I'm using the notion of skilled nursing as the rehab side of nursing, so it's the short stay. So, under one facility it may be licensed as a nursing facility, that there is a skilled side, typically Medicare, in terms of sort of major government program.

Judy Faulkner – EPIC Systems – Founder

What if we could create some kind of matrix that you could see which one had the same checks in it and therefore which are fundamentally the same, because I know one of the things...you know you were saying the vendors have a...I would hypothesize that one of the things they don't even understand all these differences and that might help them, because you hear people say "will you do this or will do that" and after while you don't know even know if they're asking the same thing or not and that would help a lot.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah, good point.

Judy Faulkner – EPIC Systems – Founder

The second thing was just a comment, and I have commented on before and that is what we see are two different ways that the...I mean I call it long-term post-acute care groups could use software, one is that a healthcare organization itself who works closely with those long-term post-acute cares wants the same system in all.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And there are examples of that.

Judy Faulkner – EPIC Systems – Founder

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, if we go to the very small end in the middle of Missouri, Citizens Healthcare that was one of the early HL7 stage 7 systems, is a hospital running an EHR and their physician practices are very tiny, but they're connected to the same EHR and they have adapted that to work in the affiliated nursing centers, so, not actually owned but community nursing centers sharing the same thing and creating a true community record.

Judy Faulkner – EPIC Systems – Founder

Right and that's what a number of them are saying they want. They want that community record. The other is that the long-term acute care vendor wants to have consistency across all the places that they take care of. So, they want one system for that though it may be different than many of the systems that different healthcare organizations have and I think that's another conflict that we see which way does that work, that's just a comment.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

One clarifying question and then I'll move onto Christine and Neil. In one of your slides you talked about patients discharged to post-acute care and you said patients first site of discharge after acute care hospital stay, am I reading this correctly, that it's saying 41% of patients discharged will go to a skilled nursing facility?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

No.

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

Of the 35%.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Of the 35%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Got it, thank you; that does clarify it. Christine?

Christine Bechtel – National Partnership for Women & Families

...all right, so thanks, Larry, this is really helpful background information and it's been something that I know many people have worked on for a long time. I haven't had a chance to read the roadmap that you sent out, but my question is, you know, you talked about the fact that there are a lot of long-term care facilities that are automated in some way and that they're receiving discharge summaries from hospitals, you know, faster. Are you seeing any uptake of like the Direct protocols to do secure e-mails and is there anything that we could do in Meaningful Use to accelerate that?

And I think the rationale behind my question is to make sure that that's something that is in fact useful for the long-term care hospitals, because it would I think help hospitals or primary care, whoever is, you know, really shifting in that transition, it would actually help them in Meaningful Use to have additional trading partners, right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

Christine Bechtel – National Partnership for Women & Families

But is it useful even though they can't take it and digest it as structured data, is it still useful for them to receive it electronically in a timely fashion and is that something they can incorporate in their workflow?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, we'll have to find out we're just at the beginnings of seeing the access to Direct as something that is being supported locally beyond true pilot work. So, in particularly the Massachusetts initiative that's looking based in Worcester, Mass, that's looking at creating community information exchange, community-wide information exchange, is looking to have that as one of their options by maybe October this year, effectively really year end.

They are also exploring building some bridge technology so that if you don't have an EHR but you have information you could share some of it and they'll do some packaging for you or you could key it into a website. So, we'll see how those kind of hybrid things play out. At this point I think there is still a need for sort of the primer on Direct, what do you need to sign up and is it general or do I just need to find a health ISP and then they'll walk me through the process? So, there is a lot of collective learning still happening on how to make Direct work.

Christine Bechtel – National Partnership for Women & Families

Yeah and that was what I was going to ask as well is, you know, maybe there's a way that ONC could work with CMS to think about how to get more materials to the long-term care community about Direct and how it works, and how to use it, and it would be nice to have a directory of people on, you know, using something that is compatible so food for thought.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks, Neil?

Neil Calman – The Institute for Family Health – President and Co-founder

So, a quick question, two questions. So, what's the overlap in the vendor community between the acute care hospital and the long-term care? Are they for the most part different vendors that are supporting these organizations?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, yes and no. So, historically it's been very separate spaces. There are some organizations like McKesson that have historically been in every space but with isolated products that aren't integrated, but we're seeing more of a move for the traditional mainstream hospital-based players to not just integrate with an ambulatory system and this is now on the vendor side, so a vendor could offer both hospital side and ambulatory side practice and create a common technology base.

But those vendors are now requiring companies that either have technology used in the post-acute long-term care space or are creating a product in that space, or are working with their customers to get into that space. So, I think there's a lot of exploring going on. There is some consolidation of some vendors getting acquired, we'll see what happens.

Neil Calman – The Institute for Family Health – President and Co-founder

Thanks. My second question is about sort of transferring functional status information where it seems like it would be...we've talked about this sort of in general, but it seems like that would be one of the really critical issues here. So, is there a standard way in which functional status is being trans...that kind of information is being transferred from one organization to another, along with sort of care plans of what people's expected outcomes of rehabilitation and other things, you know, what's their expected functional status given optimal care?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, those are all hot topics for discussion and I think you've nailed it in terms of, you know, functional status and the care plan, especially knowing what the outcomes are intended to be and, you know, that's what the Longitudinal Care Coordination Group at the S&I Framework is working on, but there isn't a good structured standard today.

If you talk to people about the existing use of electronic systems to facilitate transfer from one setting to another they really see it as the electronic system is my notification tool, it tells me there is something there and then I make phone calls or I print stuff out or I get faxes. So, it's a very sort of multimedia multimodal thing going on that in the end relies on human to human communication and a lot of human beings bridging those things.

Neil Calman – The Institute for Family Health – President and Co-founder

You mentioned that you're getting a lot of information already sort of in printed out kinds of transfer documents, but is that included in those even though there is no categorical way of sort of describing it? Is that kind of information being passed now between organizations or is it just missing?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Generally it's missing or pretty minimal.

Neil Calman – The Institute for Family Health – President and Co-founder

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I guess to reinforce the care plan piece, you know, we've talked about advance directives and they're a very tiny piece of expressing someone's intentions of what they need to do with their lives and how they're going to get on with their life and the care plan become a vehicle. So, care plans can be written completely from a clinician's perspective and we're talking about, you know, the human body as a machine that we're tuning or they can be written really from the patients, individual's perspective of this is what I'm trying to accomplish in my life and the things that are important for me and the interventions are a means to get there. And so, it's that second kind of care plan that really becomes a value in the longer stay environments where you can't just treat someone as a machine because that part is now in sync or it's as good as sync as it's going to get and now we need to make trade-offs.

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

Larry, this is more of a conjectural question, there has been a concern that Meaningful Use and the certification of electronic health records may have stifled innovation in the Healthcare IT marketplace, that the kind of creating that floor and the attention that has gone into meeting the requirements may have hindered progress in the kind of more platform based app approaches, lightweight and that if you set the outcomes and the payments accordingly then we could kind of unleash that innovation without specifying the actions and the structures of care.

The LTPAC community provides an opportunity to look at that hypothesis as kind of counterfactual. Is there a bright...is there a silver lining here? Is there in fact some, you know, innovation that we're not seeing perhaps as much of in the areas where there are eligible providers in hospitals in the LTPAC side?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, it's interesting. So, historically, I've talked about that as niche applications that are disconnected from each other in a care setting and people coordinate stuff with a swivel chair interface from one computer screen to another computer screen, but it's interesting to think about those as actually opportunities for innovation. One of the things that I see happening is doctors are getting systems of their own, some of them have had them for a long time, some of them are newly acquiring them and they're going, well I now have this EMR that I use and when I come to see a patient in one of these other care settings or I'm working with a patient in one of these other care settings I'm still keeping my notes in my now electronic medical record and I want to send you my notes.

And so I think we're going to see sort of exchange drivers happening not at the level of sort of a CCD, the care is over I'm sending a complete thing. But, here's my progress note, so it's just a piece, here's my most recent physical exam of this patient that I'm now seeing every three months. So, it could be snippets of information that gets handed back and forth and so the need for coordination of information at sort of, you know, HL7 version 2 messaging level I think becomes important because people now have outsourced services. So the doctors are an obvious one, doctors are now getting things, labs is another one where, how do I integrate labs into my local system in a way that's useful. So, we may start to see that emerge as there are pieces.

But, the other countermeasure is there's not a lot of tech environment in these settings. So, the bigger organizations, you know, like the one I work for, we have centralized technology for hundreds of locations but if you are a solo place, you know, there is no tech infrastructure, there is no tech department to turn to, to say integrate these pieces. So, if they don't come pre-integrated at a pretty consumer friendly way...

Farzad Mostashari – U.S. Dept. of Health and Human Services – Office of the National Coordinator for Health Information Technology

So, I guess my request is for your group, if there are examples of disruptive innovation that are emerging in this area we'd love to hear about them.

Madhulika Agarwal – Veterans Administration

Just on that note, let me tell you that, you know, since VA is an integrated healthcare system and we've had the electronic record for over two decades, more recently, just along the same lines, there is a pilot project that's underway of handing out iPads to the caregivers of those who have had serious injuries. So that the caregivers who are providing care have the information that's kind of needed at the point of care to them. It has just been launched and I'm sure there's going to be more information available. So, we should probably bring it up later.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks, Deven?

Deven McGraw – Center for Democracy & Technology – Director

Dr. Agarwal, I don't know if you realize how well you teed up my question, but my question is about getting critical information to caregivers which seems like an important component of ensuring care continuity, good transitions and good care for the patient, particularly in the home healthcare setting but certainly not exclusive to that. So, are there any issues that we need to be paying attention to either from a policy or technology stand-point to ensure that caregivers are in the information loop in the way that we're trying to make sure that providers are?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, this is sort of a push/pull thing. Given that there aren't incentives today a lot of the actual incentives are market forces.

Deven McGraw – Center for Democracy & Technology – Director

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, consumers asking for more information is going to drive providers and then their vendors to be able to deliver that information.

Deven McGraw – Center for Democracy & Technology – Director

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think that this...there is a strong recognition that care doesn't end at the boundary of my site anymore. So, a nursing home sending someone to home health in the past, you just used to say, you know I have a home health agency, I have a good relationship with and that's all I need to know.

Deven McGraw – Center for Democracy & Technology – Director

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And if they have questions about someone they'll get a hold of me. And now that nursing center is going, I guess I need to know what's happening with them in home health because my acute care hospital is asking me to know.

Deven McGraw – Center for Democracy & Technology – Director

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And, so I think we're increasing the pressures on all the providers to make a good connection to the individual and their care team, their caregivers so that we do have good clean handoffs and we're not, you know, we're not having re-hospitalizations and other healthcare issues come up from lack of communication.

Deven McGraw – Center for Democracy & Technology – Director

Right, but you're not hearing generally, from the folks you're working with about policy issues that we need to resolve in terms of people who actually do ask for the information getting told that they can't have it or, you know, HIPAA bars them from getting it, I mean, are there things that we need to resolve along those lines? That's sort of where my head is.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think I'm hearing more of a provider anxiety, that at this point they're not highly automated, so if someone says they want an electronic copy of their record, it's well we're really on paper and the piece that's electronic we archive to paper, so we'll give you a paper stack. But, I expect, as people move towards more electronic that, that is going to become a need and people are going to be asking, because as an individual getting care we don't always make the distinction of, oh you don't qualify for Meaningful Use so you're not going to be able to give me something that this other provider who does qualify for Meaningful Use can give me.

Deven McGraw – Center for Democracy & Technology – Director

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Thank you, I really liked Farzad's question, I think that is so important in what is happening in innovation. What trends do you see in innovation and is there in the long-term care world are the vendors approaching that in an innovative way and what are they doing to really move to form that integration of records? What do you see happening in the future? Is the business case there really? And if you go to accountable care is the business case not getting stronger? And when you're going to get paid...if you're not going to get paid for readmissions, what's the pressure downstream to make sure that you get that, that there is that care coordination? So, give us a little view of the future as you see it before we go to lunch.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I feel like there's an actual interesting challenge in there. There's a lot of technology that's being addressed to people managing their health and providing support in home, at home long-term and that ranges from everything from, you know, the heart rate monitor that ties into my mobile device that, you know, Bluetooth when I get home or cellular while I'm, you know, on my jog, is communicating back to some cloud service and I get home and there is this lovely path of the route I took from my GPS and how hard my heart was beating and, you know, what the elevation changes were and all of that. So, people are beginning to do this on the healthy side as consumers and that's putting technology out there that's not medical grade and so the providers are very reluctant to sort of get involved but it's clearly changing the landscape, you know, and then we move into stuff that is more medical.

So, now the Glucometer that I'm using at home is smart and it can plug into my smart phone and it can play that game as well and so a diabetic can track glucose levels or I can have a smart scale at home and that consumer smart scale that can track my weight and my diet could also be used by a congestive heart failure patient to track, you know, potential fluid gains and so we're getting a lot of stuff happening. There's a lot of the home is getting wired.

Today, that doesn't bridge very well too any electronic systems and so I think there's going to be a huge challenge as we get more and more...so, you know, Farzad's question about disruptive, so disruptive innovation is typically it's inexpensive, it's not really good enough but it is good enough and we start using it to do things with.

And, so we're going to see a lot of that happening in the consumer space and it's going to hit these providers first because many of them are providing a home for someone. So, how do they bring that technology in, in a way that doesn't expose them to liabilities? So, now I'm using this scale that is just a consumer grade scale to do weight management for somebody. Is the scale accurate? Is it accurate enough? It's accurate enough for at home, is it accurate enough in the healthcare setting?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

And what are the liability issues?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes, exactly and if I'm relying on software to make sense of the patterns so that I don't get flooded with all of this data, is the software good enough and where is the liability around the use of the software?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, very good; anything else?

Connie White Delaney – University of Minnesota/School of Nursing – Dean

This is Connie Delaney, University of Minnesota; I'd like to share a comment?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sure, go ahead, Connie.

Connie White Delaney – University of Minnesota/School of Nursing – Dean

Thank you. I'd like to reflect back on the discussion about 20 minutes ago or so related to functional health status and just I appreciate the comments shared as well as questions and want to particularly note that the discharge planning work, particularly with functional health status is a strong contribution of nursing as well as related healthcare providers and the more that we can potentiate and enable this contribution, the more we'll be able to address this very key need. It does include the patient's family perspective usually as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good, thank you, Connie. Okay, with that I want to thank you Larry, it was a very rich discussion and we're on time so we'll take our lunch break and reconvene at 1:00 o'clock, thank you.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Would everybody please take their place, would everybody please take their place and we'll get started. Okay, operator, if you'd open the lines please?

Operator

The lines are open.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much. Paul, we're ready to start.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, well, welcome back for the afternoon session. We're going to start off with a report...we had a couple days of very meaningful hearings, let's see, I think it was about a month ago and this is...the first one was on clinical quality where we explored sort of the quality measure supply chain and looked at some of the experience from the field in dealing with the clinical quality measures and with a view toward Stage 3 and what we can do differently or what do we need to do differently.

And the second day was on patient generated data and also had a wide-ranging panel that talked about how do we get more information from the patients and caregivers directly to contribute to their health record and to their healthcare. So, David Lansky who is on the phone is going to report out from the Quality Measures Workgroup and Eva Powell is going to be reporting out for our Patient Generated Data Hearing. David, are you available?

David Lansky – Pacific Business Group on Health – President & CEO

Yes, Paul. Can you hear me okay?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You're on.

David Lansky – Pacific Business Group on Health – President & CEO

All right, hopefully you can hear me and follow the slides, let me know if either presents a problem. We had a hearing as Paul said on the 7th of June and I'll just add that it wasn't per se on quality measurement although a lot of the discussion was about measurement, it was really more broadly on whether the HITECH Meaningful Use Program is moving us into greater capabilities to improve quality of care. So, that encompassed not only the quality measures activity that we're all busy with, but some of the Meaningful Use functionality and especially clinical decision support and whether we're doing the right things in our program to support improvement and quality with these various levers we have at our disposal. So, if I can go to the next slide.

We had four panels during the day, a lot of really wonderful presenters and very lively discussion with the committee. I should say this was sponsored by both the Policy Committee and the Standards Committee, so we had very good representation from both of our committees at this hearing and of course very good community presenters. So, there were four panels as you see here, some of the provider organizations and quality improvement organizations talking about how they're using the tools that are becoming available, a special focus on clinical decision support, a special focus on the development of e-Measures, e-Specified measures and then a panel of vendors talking about their ability to implement the programs and support quality improvement activity. Next slide.

In the slides here today I just wanted to really, you know, from 5 or 6 hours of testimony and 100s of pages of material, I just wanted to pick out a few themes that seemed to surface and I thank Kevin Larsen and Jesse James also from ONC in helping to flag some of these topics that seemed to surface during the day and I'd welcome people on our committee to talk about other things they heard as well.

But, some of the major themes, I think from the day as a whole, that there's a lot of energy both by the vendors and the providers to address and improve quality based upon the new tools and programs we have unleashed. There has been a lot learned, we haven't done everything right and certainly in the community people are discovering ways of using the programs and the requirements that have been developed as levers to improve quality and we need to learn from them.

The phrase was suggested by one of the presenters that there is a common substrate emerging and if we think of the electronic health record and the various standards, and data, and content populating the EHR as the substrate, the question that's now upon us is how do we use that substrate to improve quality of care and there are a variety of applications or ways of exploiting the data that we want to start thinking about, but that's an exciting opportunity. We now have the substrate or beginning to have it more widely available and in a standard fashion that we can take it in use it.

And there is, fortunately then, a set of tools emerging that sits on top of that substrate, if you like, to extract data, compute, aggregate, report and hopefully then support improvement activity. So, really the challenge is how do we move from where we are today into the next generation of applications. Next slide.

A number of challenges exist of course and we heard about them all day long and these summarize some of the ones that were mentioned repeatedly despite all the work we've all done on standards, I think there's now an emerging gap, if you like, in standards around the value sets that are used to populate the EHR, that is the content of encoded data and the vendors, in particular, have been asking us for a couple months to do more work through IOM or perhaps other channels to develop standards for the value sets that will be used to populate the record.

While we have begun in Stage 2 to talk about a link between the quality measurement requirements and the clinical decision support implementation that has not really been well specified yet. So, I think we're being asked by the vendor and provider community to do more thinking about the link between those two tools. I think we heard recognition that while Meaningful Use provides, obviously, some payment incentive, the rest of the payment environment is not yet clearly driving adoption of the tools that we are advocating through Meaningful Use quality measurement and clinical decision support. We can't control that but it was certainly a sense from the providers and vendors that they get mixed signals regarding payment and what the tools need to support.

So, as payment reform happens, it may make our jobs, in a sense, easier to support these tools. We heard from a number of sites, including the very advanced delivery systems, that despite being experienced and pretty far along, there are still some pretty fundamental data problems including a lot of unstructured data sitting in blobs in the record and not...because of multiple recordings of key indicators it's not always clear what the source of truth is for a data point that is going to be used for quality measurement or for clinical decision support.

Certainly, the industry as a whole has some concerns about us, ONC, CMS adding new data requirements, new fields. There is a sense that there is a lot of data now being captured in the record and we perhaps haven't done as much as we can to leverage it, take advantage of it so we should continue to focus on exploiting what's there as well as adding what may be necessary beyond it.

And then a common comment was that an awful lot of the emerging areas require collaboration across sites of care, across provider organizations, across competitors and that we have to do more thinking about how to incent collaboration to learn from the new systems that are being put in place. Next slide, please.

So, now I'll break this up into three subtopics, first on quality measures, some of the common findings. A number of people who presented to us really thought about quality measures as means of improvement in the provider organization and that for them meant the quality measure should be about processes of care that is fairly granular, technical specific measures of process.

A competing view, if you like, was an advocacy that the quality measures that are reported up to CMS should be about major care processes with only a very few outcomes oriented measures to guide the identification of areas, opportunities for improvement but the drill down to process measures might be done locally and not be as nationally standardized. So, in a sense there are two competing opinions about how our quality measurement work in our committee should proceed, whether it should be really focused on specific processes or focus more on outcomes with process work done locally and as you see one of the presenters suggested that the government's job is to identify top 10 conditions, and a few major indicators for those conditions, and not try to drill down to dozens or hundreds of measures. So, that's something we'll need to give some more thought to as a committee.

The next point, the third bullet here is a request that we have standardized downloadable e-Measure specifications so that the vendors would be benefited if we could move toward a common plug and play methodology for distributing specifications to the vendors rather than "hard coding" them into each application and we had quite a bit of discussion about that problem with the vendors.

A sense that the data model for quality measures should be the same for the drill down that supports quality improvement that is the quality measurement data model that we report up to CMS should have the same structure as the quality analysis, quality improvement methodology or data model that we drill down locally for internal improvement work.

There continues to be a question of what measures can be attributed to the provider level within an organization, especially large enterprises given that the EHR may be associated with an individual provider, whether a specialist or primary care doctor, but the measures tend to report on a larger process of care.

And, then we heard encouragement that the quality measurement, develop quality measurement work that we are trying to do now to fill gaps should have a contact point with the clinical decision support communities. These tend to be separate communities right now but as we are seeing we want there to be a link between the improvement opportunity through CDS and the public reporting track through quality measurement and we haven't done as much as we could there. Next slide.

On quality improvement per se, we heard that a lot of enterprises, especially the more sophisticated larger enterprises hospitals and large groups are now building their own tools to do quality improvement analysis, that is the vendor tools don't necessarily do that for them, they have to build their own analytics to do that and we'll come back to this on the CDS topic in a minute. It remains difficult to support the analysis one needs to do to fully look at some of the quality improvement opportunities.

So, as organizations begin to drill down to say what are the processes we can improve in order to maximize our measurement outcome, what they want to do is integrate data across sites of care, settings of care, providers and so on and then they run into problems like the data still is unstructured, it's in text blobs in the record, some data in one site is coded differently than data in another site in their same system so that goes back to the value sets problem, and then longitudinal records often have gaps, they can't really construct a full episode of care record across multiple sites and settings, and architectures.

And then finally, a sense that it's not realistic to expect the EHR product to incorporate within it everything we're talking about including the ability to drill down and problem solve around specific quality improvement, gaps or opportunities and it was recommended that we think about an architecture which is like the App environment in which specialized vendors who may be specially skilled at looking at continuity of care issues or oncology issues, or readmission issues, those applications might be developed separately from the EHR vendor but be able to plug and play into the common EHR certified platforms. Next slide, please.

The third major topic then was clinical decision support and I think here again, the notion...that what we noticed is that facilities, again the more sophisticated ones, are building their own alerts based on practice guidelines and that's fine for large sophisticated systems that have the capability of doing that, but clearly a solo practice physician is not going to be able to build their own capabilities. So, that raises this question again of plug and play.

One presenter commented on the notion that there are national knowledge assets out there which include guidelines and clinical decision support rules and so on, but we don't have an interface to download those knowledge assets into a local EHR and turn that into an alert or a reminder that would support quality improvement or improve practice patterns. So, there are some models out there we heard about at our hearing and we may want to take a look at those and see if we can accelerate standardization or integration of those models into what we are thinking about with clinical decision support, that in turn suggests the need for standard downloadable CDS specifications much as we've talked about having standard downloadable e-Specifications for quality measures.

And then finally, we heard that organizations want to be able get down into the guts of the care goals that are being measured and so that it's tied between the goals, quality measures and the CDS is a place we have to do more work and more transparency.

And I think my final slide is just to summarize, I think some of the topics that emerged during the day that the Policy Committee may want to be thinking about over the next few months as we look at Stage 3. In a sense we're getting now closer to the inner challenges of the implementation of the high-minded goals we started with. So, the real question in some ways is what is the role of the HITECH Program and of the federal agencies in both quality measurement and clinical decision support. We can adopt standards through certification and perhaps quality measurement. We can "enforce" some standards. Should we focus on this plug and play question of how to transmit quality measures and how to transmit CDS rules into the EHR platforms? Should we go a level deeper and talk about the content of the quality measures and the content of the CDS rules?

Up to this point we have mostly follow the exemplar approach saying here are types of measures and types of CDS rules that we think are exemplary of the requirements for the future rather than specifying what they are themselves, but that's a fine line and the more we have say 125 quality measures we're beginning to pretty much enumerate a set of performance requirements and that's beginning to be seen as onerous. So, we'll have to think about how do we manage to stay on the exemplar side of that.

Should we assure that certified EHRs can capture information for policy relevant purposes? And that is, should we be saying here are the data fields that should be structured and standardized because Medicare programs for example will be looking at those data points in the future for pay for value or other programs.

And then, finally should we assuring that a certified EHR can support drill down quality improvement analysis and monitoring or is that outside of our purview and it's really up to the vendors to compete and talk to their providers about how to support those functions. So, is that a federal role or not?

And then the final question, I think we have to give more thought to now that we've surfaced it in Stage 2, is should clinical decision support and quality measurement be tightly linked and focused on the same parameters and the same processes or should they really be purposefully separated in which CDS, this is one of our presenters made this suggestion, if clinical decision support is really about prescriptive process guidance whereas quality measurement is really about outcome evaluation and that they should be separate, not tightly linked, so that's a challenging question for us.

So, I'll stop there and people who also were at these hearings may have other comments to highlight and of course I'm happy to take any questions or further comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks, David. Why don't we spend a few minutes on...especially this last slide in terms of some of the policy approaches to dealing with clinical quality as implementing EHRs, it's a combination of standards, infrastructure, the linkage between content and CDS, people's thoughts? And this will roll into recommendations of both probably the Quality Measure Workgroup and the Meaningful Use Workgroup. Christine?

Christine Bechtel – National Partnership for Women & Families

Hi David, it's Christine Bechtel, how are you?

David Lansky – Pacific Business Group on Health – President & CEO

Hi, Christine.

Christine Bechtel – National Partnership for Women & Families

I have a quick question, well, probably maybe not quick, so I have two questions technically speaking. One is, so back on slide four there is a bullet that says you need the same data model for quality measurement as for drill down that supports quality improvement, and for me, at least the way I'm interpreting that it harkens back to, I think the long-running debate that has been happening in the quality

measurement world for like ever, which is, you know, how connected processes are to better outcomes and whether you put the locus of accountability on the outcome or the performance of process and that has been a long running debate and I think not one that we want to reopen here.

So, my question, first question is can you help me understand the technology implications of this notion of needing the same data model and whether or not that puts us in a position of really being able to support only the sort of process measures at the end of the day, you know, potentially at the expense of or maybe limiting the focus on the bigger picture outcomes measures?

David Lansky – Pacific Business Group on Health – President & CEO

You know, I probably can't. I think it's a really great question and you formulated it very well. And, as I think about it, I look at the discussion that maybe Eva will tee up in a minute, about patient supplied data and so the architecture questions of how do we link, capture of data from patients in a variety of ways, especially those that maybe outcome measures both patient experience and health status, functional type outcomes, those quality measures of outcome how do they link back to processes, is as you said, a really long-running challenge.

So, I don't know what the data model, maybe a question posed to our Standards Committee colleagues to think about the data model implications of this linkage, but I don't think we've had that explicit conversation yet across our two big committees.

Christine Bechtel – National Partnership for Women & Families

So, I think, I guess what I would say is I don't want to reopen the whole discussion of process v. outcomes here, but I would say that, you know, maybe we reframe that question to say how do we support both purpose of quality improvement which does require more of a focus on individual processes and at the same time enabling a more robust kind of quality measurement that is more, you know, outcome based and much more patient centered so, it's not, you know, we don't get into a data model that limits either one because both are really needed.

The other question I have is going back to slide 7, which I think those are really the important strategic questions about the HITECH role in quality measurement and decision support. I think the piece that I didn't hear you speak a lot about was the notion that...I think it was two meetings ago, we talked about Meaningful Use as a testing ground for, you know, more innovation in the development and use of more robust quality measures, you know, potentially working with specialty societies and others so that we don't get the Meaningful Use and the Health IT infrastructure bogged down in only the current model and thought processes around quality measurement but that we also think about it as a grounds for innovation and testing of new and different, and better ways to measure and improve quality that is enabled by technology, given especially the fact that there aren't thresholds that providers need to hit for performance, that what we need to do is really innovate here. Was there any discussion of that in the hearing?

David Lansky – Pacific Business Group on Health – President & CEO

There wasn't much. I think the nature of the people who were presenting came at it for more of a point of view of trying to manage their own organizations and products. There were a couple of people who indicated having more national clarity about a shorter set of measures that were of high relevance to the providers in each condition or each specialty would be valuable. But, I don't think in the broad concept of using Meaningful Use as a test bed was specifically addressed, but maybe others heard that that I missed.

Christine Bechtel – National Partnership for Women & Families

Well, if that's the case I would just suggest that perhaps it's one strategy that the Workgroup could explore because we've got a lot of work...the point is valid, but we have a lot of work happening in the measured application partnership and otherwise to come to a more focused set of priorities for health improvement for the country and we have the National Quality Strategy, we lots of stuff in ACA for those elements, and then we've got, you know, organizations like MAP and others who are trying to execute against that and I don't think we want, you know, to open that debate here. I think that debate is happening elsewhere, but, you know, perhaps the Workgroup could really think about Meaningful Use as more of an innovative testing ground so that we can reduce the angst that providers and purchasers, and consumers feel around how do we get to a better set of measures.

David Lansky – Pacific Business Group on Health – President & CEO

Thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Which reminds me, there was a suggestion to support new measures is the possibility of getting a waiver for it. So, let's say there's x number of core measures, then if an organization is developing a measure that may not already be NQF endorsed on something very important to them and goes through similar to an NQF application, describes the background, the scientific basis, etcetera and says and this is what we're measuring, that might qualify for them waiving one of the core requirements and substituting this innovative measure they developed as one feeder system to new types of measures. So, that was one suggestion that came up during the hearing.

Any other comments on a couple of the questions David raised, one is the linkage between CDS, clinical decision support and quality measure and another is how prescriptive should Meaningful Use be in terms of the content of quality measures versus preparing the EHR tool by using exemplars? David?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, on the first question, I guess they should be related because the decision support does have the condition based on the quality measure, but the measures tend to change over time so I don't think you can hardwire them. You know, it seems to me like what's most important is to begin to build some of the value sets so that we can identify definitions and then not have to do a lot of work around repurposing them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other final comments? Charles?

Charles Kennedy, MD – Accountable Care Solutions, Aetna – CEO

I think this notion of an infrastructure to support clinical decision support and quality measures is pretty fundamental and pretty important. One of the things we're noticing in our roll out is we're starting to see errors in some of the clinical decision supports and outputs and to give you an example, colonoscopy. Through one of our subsidiaries we'll use claim data, right? And identify whether a person has had a colonoscopy or not and the recommendation will be the HEDIS recommendation of every 10 years, but we won't know that there was a path report that said the person had polyps and the right answer is 3-5 years.

So, I understood that error because we had claim data, but now that we're also in the clinical world I find EMRs making that same error. They will know from a path report perspective that the person has polyps but they haven't incorporated that into a decision support algorithm that gives you the ability to actually give the right advice and I think the common thread is we don't have a single understanding of the patient, you know, everybody has their own perspective of the patient and until we have that single common understanding of the patient composed of, you know, some the text-based information as well as discrete information, I think our ability to go down the clinical decision support path is actually fairly limited.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good, thanks. Marc?

Marc Overhage – Siemens Healthcare

Yeah and my comment was kind of similar to what Charles was saying, you hit the concept of portability a couple of times, you know, can you share these rules or quality measures and, you know, to really be able to do that it requires standards and I think it would...you know, three years ago had we defined those standards as part of what we were doing I think that would have been a very meaningful step for us. Today to do that and require the vendors to make the modifications to, you know, meet these standards in the timeframes of Meaningful Use I think would be pretty challenging, but I still think it's something that ought to be pursued, I'm just not sure it's part of Meaningful Use, you know, Stage 3.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks, Neil? Final comment.

Neil Calman – The Institute for Family Health – President and Co-founder

I would just...I know Judy is happy with what you said, Marc, but I would disagree because, you know, I think what Charles said is absolutely critical, that is exactly the reason why we need to do something that cuts across organizations because how many times will that lesson have to be learned in this country before we, you know, use a decision support that doesn't take that into account, but if you call it out then basically you're forcing people and systems to say, wow we really need to have a way of capturing whether or not a prior colonoscopy was normal or abnormal, we might not need to know whether it's a three-year interval or a five-year interval but there's got to be a way of capturing that and we can't actually implement this standardized decision-support unless we have a way of capturing that, because otherwise it's going to be inaccurate.

And we run into this...I mean there's dozens of examples like this and so I think that it's exactly because of that kind of learning that people...that we need some sort of standardized system and yes it might be that we can't implement this advanced decision support in my system today because I can't capture that information but it calls out the need for the information in order to create an accurate decision-support and I think that's the learning we shouldn't have to do, you know, 100 places across the country, that's what we ought to be able to share with some, you know, more standardized knowledge-base.

Marc Overhage – Siemens Healthcare

I actually think we're in violent agreement, Neil.

Neil Calman – The Institute for Family Health – President and Co-founder

We are.

Marc Overhage – Siemens Healthcare

I mean, I think that's the power of the EMRs, it's just to try and do it in the timeframe that we have is putting a huge burden on the vendors and the people that build these systems.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I just want to remind people that, that was incorporated in the value set standards and the prototype was ejection fraction this is another excellent example. So Judy, final and then we'll go onto Eva.

Judy Faulkner – EPIC Systems – Founder

I think there were three things, one was infrastructure, two was utilizing data from the outside and three was the knowledge to make these decisions. Number one, on infrastructure, as I'm listening to this, I'm not sure that it would actually require much in the way of infrastructure. When I first was listening to it I was thinking okay there's a building up and you're going to take the steel girders out of the bottom of that building out and put new steel girders in and that's hard to do, but I'm not sure that really is the need. I think a lot of the vendors who have developed the ability to do various alerts and advisories can do that and health maintenance has built in a lot of flexibility that is going to already work. But I think the...but some may not have and then for them it's going to be very difficult. So, there's a mix on that.

Secondly, I think utilizing the outside data, yeah, that's gigantic and that's what I think the interoperability discussions are based around. And the third thing, which I don't think has really been discussed, and Charles's example is a good one for that, which is for the most part a lot of that has to come from clinical folks telling the vendors this is what is needed so it isn't really that the vendors need to do it, it is that the vendors need a way to let the community of healthcare folks do it for two reasons, the vendors may not have the clinical knowledge and all the different specialties number one, and number two, and to keep it up, it's not just to do it the first time, it's to keep it current. And number two the vendors may not be comfortable with the liability that goes with the clinical decision-making that they put in that the clinicians themselves have to say this is how we want to behave.

Madhulika Agarwal – Veterans Administration

Thank you, Paul. This is going to be an interesting challenge and you're absolutely right, you know there are many professional guidelines and recommendations that come forward. I know for VA we follow certain sets, the US Preventative Taskforce as an example, but in classic examples that you're citing, you know, there are probably guidelines that could be used and we do that in our clinical reminders so that they are based on a Boolean logic and with some sense of what the clinicians would be doing in a certain situation and that sort of guides it. It's a fairly preliminary form at this point in time but as many of these things do change over time and I think that awareness needs to be there and I'm not sure, you know, how that would be incorporated in some of the future generations as these things change, that's an important part of it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Is it quick, Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Very quick, playing along the same lines I just want to emphasize the importance of the plug and play aspect of things and making sure that there is a mechanism in place for some sort of either certification or approval, or something so that you have the ability to change over time as those guidelines change, you have the decision support that is appropriate for those guidelines and that you have the plug and play aspect in place that has a process it goes through so that you ameliorate some of those liability issues and that there's confidence in them. So, it's a long-term project that's never going to end.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, let's move on. Eva is going to report out on the patient generated data. Thank you, David, it has obviously stimulated a lot of discussion, I'm not sure we solved everything but that input should go into both quality measure and the Meaningful Use Workgroup in terms of recommendations for Stage 3. Eva?

Eva Powell – National Partnership for Women & Families

Where is this?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's a different set, different PowerPoint set.

Eva Powell – National Partnership for Women & Families

Well, I'll go ahead and start while we're getting the slides up. This is going to be difficult to summarize a very rich discussion in about ten minutes. So, I encourage everyone to fill in the gaps during the discussion if I've left anything out but also I encourage everyone to read the blog because much of what you'll hear from me came from there and there is much that I did not put in my presentation. And then also the RTI paper which I won't spend a ton of time on is worthy of a read at least of the executive summary.

The day started out with the presentation of a white paper commissioned by ONC to RTI that gave some really good background information, it provided a broad definition of patient generated data and made some important distinctions between data capture, data transfer and data review. And, I think you'll see those come into play a little bit later on in the conversation. They listed some barriers which included processing power, not all patient generated data is of equal value and that that varies by situation and health literacy.

So, moving on, I do think it's really interesting and important that the patient generated health data hearing came after the quality metrics hearing because as I was reviewing some of my notes and the notes of ONC, and the blog post there are some recurring themes not just within this hearing, but from the hearing that we just heard from David about and I think those are important things to note.

So...yes, thanks, thanks, okay, okay, so, moving on, so major themes of all of these various sources of input, first of all patient generated health data is crosscutting and it has applications in every one of the Meaningful Use policy priorities and so that's to some degree how I've structured my comments.

Second of all, specifying a plan for collection and use of patient generated health data along with the clear objectives and goals of its use is really key to successful implementation of using this kind of data and that was the theme for all of the folks on the panel who represent current users of this kind of information.

The information has to be meaningful and useful for both patients and providers otherwise you'll be behind the eight ball in trying to do this. And then one of the recurrent themes from the previous hearing is the fact that modularity and the ability are critical components, that, as I said before, all patient generated data is not equal in importance necessarily and that varies widely by circumstance, and so it's kind of unrealistic to think that we are going to get terribly specific as a national policy committee to being able to define some low level of specificity on this.

Other major themes include the fact that attribution of source is critical but that this is not specific to patient generated health data. All information has to be specified in terms of who is the source and perhaps even the mode of source as we move toward integrating data from multiple data sources.

Standards was a huge component of the conversation and so obviously those are important, but there were also points made that the sharing of information really is paramount and so I think that that leads to a policy question as to what exactly do we need to standardize and what do we need to leave for local innovation.

The other thing that came out was that it is not a safe assumption to think that there are no standards that enable patient generated health data. There are actually quite a number of existing and commonly used standards that accommodate this data, and that whatever standards are developed in the future or used currently should follow the same pattern as all other information, and again I want to emphasize the point that this is unique information and that it's information we've never had before, but otherwise this information should be treated exactly like every other piece of health information at least in terms of the policymaking around it, that this is not special data and therefore needs more scrutiny than other data necessarily.

So, I'll go through each policy priority and just highlight some of the key points as I saw them from the conversation and as I think all of our work has shown in the Workgroups as well as in the Subgroups that as we continue our conversation into Stage 3 and toward a more coordinated health care system our policy priority areas are merging more and more or overlapping more and more I should say and so you'll see that here, too. These are not neat and tidy categories but I thought it might be helpful to look at the comments in this way.

First of all, and this is another point of overlap from quality measures session, was that patient generated health data can be a triggering function for CDS and that, as was mentioned before, there is this recognized connection between quality measurement and CDS, but there's still the question of exactly what the nature of that connection is and so that is a policy question for us as well.

That PGHD can be pivotal in addressing disparities through such things as patient activation measure, which has been shown to be a quantifiable means of collecting data from a patient, something that can change over time with efforts, and it's also been shown that patient activation tends to be lower in underserved populations, so that would be one example. Also language information and having patients record some of their specific needs can help address disparities as well.

The work done by the PROMIS work should be leveraged; there was a lot of discussion about that. There was also the suggestion that since PROMIS is proprietary that there should be some method of mapping nonproprietary scales to PROMIS to enable comparisons and wide use of data and aggregation of data, I'm not sure exactly how that would happen, but the suggestion was made.

For patient engagement, this is...patient generated health data obviously is critical for not just patient engagement but for shared decision-making and that would be on both the individual and population level. I think on the individual level that's pretty easy to see in the sense that you incorporate patient values, patient preferences, some of the realities of the patient's life that may impact decision-making and in that way it impacts individuals shared decision-making, but at the population level if you are collecting certain key pieces of information that are commonly used by the patient to make decisions then you can start getting at information that's truly useful to patients and physicians and making decisions such as...you know, I know what the clinical trial says, but that's not relevant to any single individual here because it's a clinical trial and highly controlled. What about patients like me? What about someone whose disease manifested itself in the way that mine did, what can you tell me about likely outcomes there? And so in that way it's critical for patient engagement and decision-making.

And then the use of assessment scales came...was mentioned again and again as an interesting starting place and one that would be very realistic because of the nature of the data and that can be useful not just for individualized care, but also resource allocation from a workflow perspective in terms of data that is now being recorded by staff but whose source is always the patient if you allow patients to be a partner in that way then you eliminate some workflow for staff, but also in the sense of using scales to allocate limited resources in terms of depth of assessment or staffing requirements for certain times, or certain areas, and so it has important uses there as well.

In care coordination, Nikolai, I think was the one that came up with this notion of thinking about the patient as an HIE of one and that's not to say that all HIEs should be on the patient's shoulders but more highlighting the critical need to begin collecting and using this data now. As we just heard there are lots of barriers both in the quality arena and connecting data sources but just also in the process of care through CDS and other tools that the provider world is not yet connected enough to make that the only source or to squander the patient as a helper in this process and so it's critical both from the perspective of where we are but also ongoing to think of patients as having information that no one else has that is not just critical to their care but often life-saving.

Creating a supportive environment between encounters is also a huge part of coordinating care but also limiting readmissions and addressing some of our resource, and efficiency challenges because often times patients are readmitted because of either not knowing what they need to do at home or not having the kinds of support they have and so this notion of a two-way communication loop where both patient and provider are acting on information they get in between encounters with the healthcare system will be critical.

Collection of caregiver status is a little more specific than most of the bullets I've mentioned, but I think this is really important because this is data that's not yet collected or at least not consistently and this could have a huge bearing on the whole process of care coordination and so that's obviously something that would have to come from the patient themselves not from the provider in terms of the original source.

And then finally, the use and availability of community resources, this is one way that patient generated health data on the population level could help more broadly to identify common gaps. Public health, there are implications for adverse events and safety implications, and safety uses. Post market surveillance of patient experience of particular information or particular treatments, the use of information for setting of expectations and decision-making which we've already talked about in our certain applications.

Than privacy and security, the main thing mentioned there was the need for data integrity and sourcing for metadata to provide context, but, again that is not specific to patient generated health data necessarily, that is a need for all data. Patient authentication is something that is somewhat specific to patient generated health data and that having a means of doing that is really essential for trust in the system and then as we said before, the mobile platform is really where things are headed and that that needs to be accommodated from a privacy and security stand-point as well.

So, some potential next steps for the Policy Committee and the policy questions that we'll need to grapple with, the first one I think is how do we design criteria to require the collection and use of patient generated health data but not over specify and to leave lots of room for individual variation by necessity depending on the patient's situation and need for information, and possession of information, but also how do we be prescriptive enough so that we can satisfy the real needs out there to have some degree of standardization and specification for both the vendor world as well as providers to have some adequate guidance.

So, there were a number of inputs on the blog about specifying the "how" in other words, the transport kind of mechanisms but being less perspective on the "what" and so I think that then begs kind of a second-tier of questions which is, would it be useful to our overall purpose to create a limited patient generated health data set and I'm not sure that the answer was necessarily yes or no based on what we heard, but that that's one thing we could discuss further.

And then finally, there were suggestions, as the conversation and as the conversation on the blog continued, about places that the Policy Committee could start with all of this and some logical and achievable starting places are the pre-visit communication, we've already built in the ability for patient messaging and so that then is something that can be built upon for generating some important information to have available within the encounter. And then, as I said before questionnaires and responses that already are validated and there are existing standards that would support the use of these. So, with that I will leave it for questions and discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. I think I will clarify one, you talked about PROMIS, I think PROMIS was developed by NIH so I think that nonproprietary.

Eva Powell – National Partnership for Women & Families

Okay, okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And so I think one of the suggestions that was made was to map some of the proprietary...

Eva Powell – National Partnership for Women & Families

I gotcha, okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Tools to PROMIS, because it's nonproprietary.

Eva Powell – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great. Comments, questions? Deven?

Deven McGraw – Center for Democracy & Technology – Director

I think the only thing that I remember and I think it's related to this point here was one of the witnesses, Patti Brennan in particular, saying that at least with respect to the aspect of patient generated data since there is a lot of different kinds of patient generated data, but at least with respect to the aspect that is sort of data coming in from the patient that really whether it's verbally or electronically, or through some other means, that the physician then or the clinician relies on in making a judgment that we called it leaving room, that there would be space in the clinical record to be able to document that.

Eva Powell – National Partnership for Women & Families

Right.

Deven McGraw – Center for Democracy & Technology – Director

Again, whether that is through a direct incorporation of patient data or just a physician's account of an encounter with a patient that that's not prescriptive but it leaves a space and a designated space in the record for that interaction to occur and then be documented, which, to me is a slightly different way of saying that top bullet.

Eva Powell – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Speaking of which, the associated with, how do you leave space but then what's included in the "legal medical record" and what's the liability issues, so we asked ONC to do a legal review on that question, because that's something we need to deal with as we incorporate patient generated data into the record.

Eva Powell – National Partnership for Women & Families

Yeah, and I think that brings up something else too that emerged a little bit in conversation about...as we start talking about patient generated health data in particular, but the rest of how we're talking about using EHRs and Health IT is really stretching the purpose of the medical record and so that's kind of a bigger issue that is perhaps even bigger than the Policy Committee, but one that we need to maybe come back to at some point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

I have a question on the liability issue because I did not get the stay for the whole thing I had a plane that I had to get to, but...and I was hoping it would come up before I left and I was not there to hear the end of the conversation, so that is of great concern to me and can you clarify what ONC is going to do and when they're going to do it? Are we going to have some conversation here in the Policy Committee or are we going to...you know, how are you going to address that? So, we have some really delineation on what is the legal record and what is the...who is responsible, whose liability sits where?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct and those are the questions, those are among the questions. So, what constitutes the legal medical record, is there a staging where data flows to the provider and then there is in that "acceptance or acknowledge" and then that causes the incorporation into the medical record, are there timeliness expectations surrounding that? So, these are amongst the questions that we're posing to this legal commission paper I hope. So, maybe ONC can...I think it was MacKenzie or...

MacKenzie Robertson – Office of the National Coordinator

So, we're still discussing it internally on how to respond to those questions but we're working on it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Those are beyond sort of the expertise of the people on the Meaningful Use Workgroup for example and we are...unless you already have that, Deven?

Deven McGraw – Center for Democracy & Technology – Director

Well, I mean...the one thing that I did note in my testimony, this is Deven speaking, is that we have a lot of experts on the legal medical records that exist, AHIMA being one of them maybe HIMSS being another and we just did not specifically ask them to give a presentation at this hearing, but we should be reaching out to them because, you know, in essence when you sort of look at entities that are already engaging in patients collecting their data and incorporating some of into the clinical record, you know, the experiences is it's not sort of this unmitigated data flow but it's very planned and very measured and nothing's going to come into the actual record that the physician isn't actively using as a part of care. So, you know, it's not...I guess to me it doesn't seem that complicated. I think the trick for us is not to create a set of mandates that make a situation that's capable of being managed worse.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Neil?

Neil Calman – The Institute for Family Health – President and Co-founder

Well, just a brief comment that we shouldn't get too paranoid here because everything that we write in the medical record under the section of history is patient generated. I mean, the fact that we're actually typing it doesn't really make it not patient generated and somehow we trust that, we put it in the record, you know, we put it in with all kinds of qualifications like "patient said" and "patient claims" and all these other...we have all this lingo that we learn so that it's clear that it's not really us saying it but it all is part of the patient's history. So, that's one point.

The second point is that secure messaging runs into some of the same issues as this patient generated data stuff, it's anytime somebody sends a message to a provider you have exactly the same issue, does the message itself get incorporated into the record, you know, does the message and it's answer get incorporated into the record. I think all of those things are...we're dealing with those already so it's not a totally new issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I agree with all that and I think it will be of a lot of value, at the same time I think it's worth spending some time on this because especially, there are always some individuals who are two standard deviations out and I've been reading for example about the quantified self, there are people who are collecting great amounts of data and we probably don't want to incorporate all of that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the difference on paper Neil is kilobytes versus gigabytes.

Neil Calman – The Institute for Family Health – President and Co-founder

People will be uploading their genome.

Eva Powell – National Partnership for Women & Families

Well and the testimony I think...the part of the testimony that helps address this, kind of along the lines of what Deven was saying, is that it's not automatic that you necessarily will be uploading your whole Facebook or anything, that those who've been successful found that virtually none of their concerns were manifest and that's because those who were successful had a very specific and clear plan for collecting and using the data before they ever started. So, I think those are really important lessons.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, Jodi, did you have something?

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

So, I would just say that the issues regarding liability continually come up, they came up again in the context of this hearing, they've come up in other context, what we're right now exploring is how we can try to get a greater handle on what some of those challenges are not because we want to try to set requirements or make any kind of onerous activities but there's probably some best practice out there, which we heard, for how to deal with some of this stuff and to the extent that we can get some smart folks to give us some input on what those might be and how people might think about those and help convene folks around those issues, we're looking at how we might do that. So, patience. No promises...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

They will be very useful. Any other final comments? Thank you, very much, Eva, it was a very informative and thought probing hearing. Okay, so now we're going to have an update from Jodi and Lygeia on some of the activities at ONC.

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

All right, well thank you very much. Paul had asked...Joy Pritts and I had done an update at NCVHS and Paul had asked if perhaps it would be a good time to do another ONC update here. I don't have Joy's...the privacy and security material, Joy has offered to come and brief next time on some of the work that they're doing so that's not included in here, but she's more than happy to do that next time. So, I think we'll just add that to the plan for next meeting.

So, I just wanted to go over some brief things, a lot of this folks sort of have already talked to or heard about, it's just to give a little bit of a flavor of some of ONC's perspective on some of these things and some of the work that we are doing in ONC, make sure folks know about different activities that are going on that either have just happened or that are coming up. So, I won't be too...I'll be fairly brief and then turn it over to Lygeia to talk about our consumer program and then we're happy to take some questions.

So, you heard from CMS so I don't need to go into detail about this, but I do think it's worth highlighting the fact that we had set a goal for a 100,000 healthcare providers to become Meaningful Users by the end of 2012 and that we achieved that by June, exceeded that and that this represents about 20% of all the eligible professionals in the US, I think it's a real testament not only to the work of CMS but to our Regional Extension Centers across the country and a lot of hard work of some of the ONC staff and I just wanted to kind of highlight the achievement that was reached in that number.

So, just to mention the Regional Extension Centers, you know, they are doing really hard work to get the healthcare providers to become Meaningful Users and are currently working with 133,000 primary care providers, 10,000 specialists and over 70% of small practice providers in rural areas, so really getting a lot of penetration into some of the areas that we really care most about and wanted the Regional Extension Centers to support and it's a real testament to the hard work of folks out in the field as well as the folks in ONC who are making that happen.

I wanted to mention we had a couple of meetings with some Health IT vanguards that just happened in June. The goal is to discuss work in achieving Meaningful Use of EHRs, there were diverse stakeholders from 34 states, we invited folks based on input from our grantees and they discuss best practices to achieve Meaningful Use but also Health IT adoption in medically underserved communities, leveraging Health IT for quality improvement and safe and secure exchange of health information. It was a really strong event and I think the folks who were there were really the vanguards in adoption of Meaningful Use of Health IT and were able to share their experiences both with us as well as with each other in how to improve our programs.

There was a follow-up the next day, a White House meeting to discuss how Health IT was being implemented across the country, it's when we announced that we had exceeded the 100,000 number and there were some success stories and areas for improvement that were highlighted.

Just to give folks an update on our certified Health IT products list were now up to 1477 unique certified EHR products and you see the breakdown between complete the modular EHRs, and ambulatory, and inpatient. This represents 816 EHR vendors and developers and what I think is amazing is that there is still 2/3 of that number are small businesses, so it really is a great success story on how we've...our programs have actually helped promote competition in the EHR market and have succeeded in making many products available for providers to choose from.

Also, wanted to let folks know that the CHPL, which is the website that we have for folks to get their certified product number to use for attesting to Meaningful Use has been new and improved, we just updated it on June 26th we made some enhancements. The main enhancement was hybrid certification and what this means is it was a way of trying to help folks who are practicing in both ambulatory and inpatient settings to use a combination of EHR technology to be able to get a single number that they can use to attest, this was the problem that we heard about and so we've modified the CHPL to make it easier for folks in that situation to be able to attest to Meaningful Use and to get their incentive payment. There are also a couple of important improvements in navigation and search functionality to help folks in understanding which products are certified and to support that activity.

So, of course our regulations, I can't really say too much, our standard certification rules along with the...Meaningful Use rules are in process, folks are working hard, we have the mice on the treadmill right now trying to get this out the door. We're working hard to try to stick to pretty aggressive timelines and to get our rules out the door, so stay tuned.

And, as Farzad had mentioned, we are in the process of reviewing comments on the governance RFI, we received 140 comments from a diverse set of stakeholders, really good input that we have received so far based on the early comments and the early assessments, really appreciate all the input, if folks want to see the comments they are on regulations.gov you can look at them yourself and see what people have said. And we are really going to take all that input into account as we determine our next steps and thanks to our approach on governance.

As Farzad mentioned, there were a lot of questions. I know of people spent a lot of time in responding to those questions and we're going to spend a lot of time in reviewing the responses everything from things like this is great, here are some little tweaks to, you know, challenges to approach. So, we've got the whole gamut of comments and we're going to be processing through those and thinking about our next steps. So, thank you all particularly for your hard work in this space.

On the non-eligible provider side, so we did get an update on LTPAC, we had a roundtable that ONC had a contractor sponsor for us that really brought together a great diverse set of stakeholders in the LTPAC space, it helped really kick off a lot of the activity that's now being discussed in the Meaningful Use Workgroup through the Care Coordination Subgroup and how to think about the LTPAC community and the needs of the LTPAC community and Meaningful Use Stage 3 so that was, I think, a huge input into that process where we got a broader set of stakeholders that are really in that space to help provide the input we need. We will be coming up with a white paper that we'll be making public that comes out of that comes out of that roundtable, so we'll make sure to share that with you all and particularly with the Meaningful Use Workgroup when that comes out. Larry already talked about the state challenge efforts. There are S&I activities as well in this space to look at the standards issues.

With respect to behavioral health, we also have a roundtable scheduled on behavioral health in July. These are sort of the two areas I would say that have been a focus when we talk about providers that are not eligible for Meaningful Use, but that are critical to the provision and coordination of care. So, we have a roundtable that's scheduled for July 24th an all-day session. If there is...it would be actually great to have a FACA member participate if there is anyone in particular who would like to participate in that event, it is an all-day event, please come and talk to me afterward and we will get you invited. It's always good to have somebody from this group who can sort of bring back some of the discussion and make sure that we have some seamless transition of information. So, let me know.

The goal is really to focus on the integration of behavioral health in primary care and understanding the data needs of providers, of the systems, policies, practices in order to ensure that the behavioral health providers have what they need and that there good exchange of information between behavioral health and primary care. In this space we also had an e-Measures Project on behavioral health and we had a contractor deliver some of the measures that they were developing in June related to behavioral health for Stage 2.

And the last thing, which I don't have up here is we are working on a project regarding prescription drug monitoring programs and trying to get information from prescription drug monitoring programs into the hands of prescribers and dispensers in real-time so that when the prescriber or the dispenser is standing in front of the patient they would get information in a seamless way from prescription drug monitoring programs in order to consider that in making decisions about prescribing and dispensing of controlled substances.

We have had groups who are working on some of the policy and standards issues, legal issues on making that happen and some recommendations and best practices and we have so far two pilots that are under way in Indiana and Ohio, and we are looking for more pilots, so the hope is to have a few more of those and to really test out making that information available based on some trigger events that would provide that information to those who need it at the time and place of care.

And, I think this is the last, I wanted to mention with respect to clinical decision support that we just kicked off an S&I initiative called Health eDecisions, the goal is to take clinical practice guidelines and put them in common format so it can be shared and consumed by EHRs. This just kicked off I think it was last month, there has been great interest in participation and so if folks are interested in this your still in on the ground floor, please go to our S&I Initiative and jump on into the conversation. This is I think a really important effort and can really help advance our abilities on clinical decision support. So, with that I will turn it over to Lygeia.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

Thank you and thank you for holding on in your attention for a few minutes toward the end of a very long day. When I last spoke with you, which was a few months ago, this was prior to the ONC reorg and since then, as I think you know, the consumer program at ONC has officially become an office which is exciting, I it really signals internally and externally the importance of consumer eHealth and I think that's probably due in part to the efforts of this group in really underscoring how important it is in the Meaningful Use context, so thank you.

So, a couple of updates, despite the fact that I recognize that I'm preaching to the choir it's always good to remember why we're even talking about consumer eHealth and what you see on the screen is an artificial heart which was implanted into a young man from Central America who spoke very little English here in US and his family spoke basically none and somehow they missed the fact that they were supposed to come in for regular and frequent checkups. So, he went into the hospital for some other reason, somebody listened to his heart and heard nothing, it turned out that the device was actually keeping him alive, but he had missed those checkups and not been getting regular sort of, you know, servicing on this part and fortunately he survived, but point being we really need to engage patients in their care if we want healthcare and health to be more successful.

This slide bears testament to that with some numerical facts showing the impact of patient engagement, in this case of patients over 50 who have at least one chronic condition and it shows that patients who are more rather than less engaged in their health are much less likely to be readmitted to the hospital within 30 days, less likely to experience a medical error or suffer a health consequence from poor communication among providers.

You know that, Health IT enables engagement through several different ways, care coordination, communication with providers and enabling people to manage their health and wellness often outside of the traditional health setting. You've heard me talk about our approach and Farzad, and also others revolving around three A's for consumer engagement, they are access, action and attitude. So, as a reminder, I'll tell you what they are and then I'm going to give you some specific updates on what we've been doing in each area.

So, access is about giving consumers secure, timely electronic access to their health information, which you all are certainly doing a great deal to advance. Action is about supporting the development of tools and devices, and services that make that information useful so people can pick it up and do things with it. And attitude is about supporting people's evolution and their thinking about consumer's roles, and provider roles, and getting the word out about Health IT, which most people are not really aware of at this point.

So, a couple of initiatives that cross all three A's, one of them, the sort of broadest blanket is our pledge program which we launched last September with about 30 organizations that are a couple of different kinds of pledges for data holder organizations who may or may not be eligible for Meaningful Use. The requirement is that they make information easily, electronically available to patients. And, as I have on the slide here, we started back in September, last September with about 30 organizations signing onto this program in general. We now have about 375 of those, roughly 100 or so are data holder organizations.

The second type of pledge is for non-data holder organizations, so all others. And they can support the pledge through either developing a tool, a technology or a platform perhaps that supports the use of this data or through helping to get the word out. And we support them in doing that by providing tools and information, opportunities for networking.

So, last month, as part of the health data initiative we held a kind of consumer track within that, that highlighted a lot of the successes of pledging organizations who had really done noteworthy things in, you know, living up to their pledges and we're planning to do some more of that and to build on it in an anniversary event, which we'll be holding this coming September, it's going to be an all-day event that again shines the light on great successes but also trumpets some of those successes to the press and also has some working sessions in which some of these organizations can work more closely with one another, form partnerships and push forward progress in all three areas.

Among other things that we've been doing under the aegis of the pledge program are holding roundtables, we've had a couple on...we had one on gaming, we've also been developing papers, you guys heard about the patient generated data paper which was used in your hearing back roughly a month ago. We're going to be doing some additional work in the area of social media. We're planning to do a

roundtable in that area as well as meeting the needs of the underserved. And we're doing some paper discovery work in the areas of mitigating unintended consequences of consumer engagement in eHealth, as well as personalized medicine. So, and just so it's clear to you, we work with members of our pledge community and try and take their pulse and understand what they're interested in and helping to inform and shape this work as well as inviting them to participate.

So, I want to tell you about another initiative that you might not yet have heard about and instead of going very broad and open this one is much more focused. This is a cancer initiative which is in its relatively early phases, but the idea is, in addition to trying to sort of boil the ocean through the pledge program, we wanted to take a really targeted use case. The use case of cancer patients and test the extent to which engagement in their health through IT can have a positive impact either on health outcomes or on their experience of their condition.

So, we chose cancer specifically because obviously it's very prevalent, but patients who have it also tend to be incredibly engaged along with their families in managing the condition over time. To kind of kick this off last month we held a roundtable in partnership with NCI and the eHealth initiative on planning a long-term research agenda in consumer engagement in cancer care.

But, we're also working on a pilot which is going to involve giving patients access to their information in a way that they can extract from the place where they're getting care, plug it into a platform and use it to share it with providers or to, you know, run it through a variety of tools and Apps. So, we've been working with several healthcare provider organizations in Texas, we'll announce their specifics in the near-term, as well as a major platform provider and some cancer organizations, consumer organizations. There will be a research component as well as an Apps developer challenge. And you can expect to know more about this in the coming months particularly leading up to our September event.

I want to dip into some specifics in each of the three prongs, some projects that are much more targeted to each one. So, the first one about access to information, we had a meeting June 4th at the White House in partnership with the VA and the White House about patient access to data and we were particularly focused on the question of how can we really turbo charge this access question? Of course there's some overlap with the pledge program here too. What should we be doing? Particularly from a technical or standards perspective and we worked with members of diverse stakeholder groups to identify some priority issues that needed work, specifically ones that were mentioned were enabling an automatic blue button function, right now blue button is just very simple, it's a simple ASCII text download, but you as a patient have to go and request it multiple times in order to get it yourself. So, how can we build an automatic function that does that?

There is also a need to do some additional work in patient identification and authentication to support that kind of function as well as to standardize content. People expressed an interest in standardizing content for claims data. A lot of folks who are interested in using blue button right now are some of the large providers or some of the large payers rather like United and Aetna, and Kaiser. So, as follow-ups from that meeting we're working through the S&I Framework and we're going to be launching several Workgroups in the very near term, and we're planning to have something to show for it, I don't want to be too specific until we really roll it out, but we really want to push for something to show by HIMSS.

So, moving on more specifically to the action piece, I wanted to make you aware of a relatively recent announcement we made of a challenge, this is a challenge for our developers, this is one that we issued in partnership with the VA and we're building on this blue button theme here. It is a \$75,000 challenge in which developers were asked to take blue button data and mash it up with other kinds of data that will put it into context on the theory that it is really is great to have your information, just your healthcare information on its own, but it's even better if you can combine it with information about something related to community norms or information from your own personal tracking devices about your body, or cost information, or something else that would shed light on decisions or actions, or encourage you in behavior changes that you might want to make. So, the winners of that will be announced in September of 2012, actually at the Health 2.0 conference.

In the attitudes realm, we've been doing a couple of good things. We recently completed a Health IT animation, this is for the general public and I wanted to show it here today but unfortunately we don't have the technology to do that, but it's fun I think and is meant to be very approachable, and it gives people a sense of the benefits of Health IT and kind of brings it down to earth. So, it's not this technical abstract concept, but it's, you know, examples of real things, what happens if, you know, your father forgets what medications he's on. What happens if your kid is away at camp and you don't have the immunization records and she gets sick, that kind of thing.

So, we're going to be releasing that on July 23rd we're doing it on that date because there is a group of reporters that's being pulled together who are going to have a chance to sort of screen it and we'll be distributing it via healthit.gov and certainly, you know, it will be up on YouTube and other places, but we're going to ask our partners, especially in the pledge program, to push the word out about this too, as well as of course, you know, grantees and we'll work with our RECs and others.

Building on that we've also been encouraging people, continuing to encourage people to tell their own stories about Health IT specifically through some crowd sourced video challenges. We've just launched one that's called what's in your record and so it encourages people to go take a look, you know, it might be something...the idea here is not to blast providers if there's a mistake but it's to make you aware that you should have an idea of what's in there and some people find things that they didn't expect, they may be discovered that they were listed as a different gender or something like that. So, we're hoping to get some colorful results out of that.

The other thing that we're doing in the near future is we're working on upgrading healthit.gov which has a section for patients and families that right now gives them basic information about Health IT and it's benefits but we want to give people links to real resources they can use and give people more guidance about how to put into effect, you know, what happens if you do blue button your data what do you do with it? So, we'll be providing that kind of guidance as well as some real links to actual tools and communities and that kind of thing that people can actually use.

The other area where we'll be doing some work again, I keep mentioning blue button and we're doing a lot of work with the VA and others in the federal government in this area and really trying to maximize the successes of blue button and integrate it into the work ONC is doing at lot. And so we'll be doing a lot with the branding of blue button and figuring out how to kind of enmesh it with the pledge program and get it out more publicly. As provider adoption get greater and as consumer adoption and the idea of access to care becomes more wide-spread we think it's time to really pave the way for a broader marketing campaign. So, that's it on the consumer front.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, lots going on. Can I ask one quick question? You talked about a paper on unintended consequences of consumer engagement. When is that due out?

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

When is that due out? That is due out in September.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

And the idea was we have a broader contract through which we're looking at unintended consequences related to Health IT more generally and we had some work that was looking specifically at the question of okay so what does it mean that consumers are getting more engaged in their health and that sounds good, but what are the potential downfalls, issues whether, you know, legal, technical, other, workflow, financial, but then we wanted to make sure that in addition to sort of just enumerating them all we were also saying, okay there are things you can do to mitigate these it's not the end of the world you know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you. Deven?

Deven McGraw – Center for Democracy & Technology – Director

I just have a quick question. So, I was at that White House meeting but I wasn't able to stay for the whole thing and I do...I am pleased that the concept of sort of an auto download is something that is being pursued, but the one question I have though is or maybe it's a word of concern, that we not be pursuing options that require people to obtain private accounts in order to take advantage of being able to access their data. So, you know, certainly people who have like a personal health record account who want to be able to auto download to it should absolutely have the option to do so, but if the only mechanism for accessing your data is that you have to create an account that something can be pushed to, that sort of forces people into a marketplace that is less well-regulated with respect to protection for health data in order to have a repository to put that in.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

So, that's a good point. I think one of the great strengths of blue button is and has been its simplicity, it's a simple concept, you don't need a lot of technology, you don't need a lot of thinking to understand it and so I will certainly advocate for, obviously this will be a community kind of decision, but I would love to see something evolve whereby a consumer pushes a blue button and then has a couple of options, just send me the ASCII e-mail or send that off into my, you know, PHR account or do something else whatever it is, but I think it would be a shame for a variety of reasons including some of the ones you bring up to lose that simplicity that has made it relatively successful so far.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, thank you, I agree.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And also, is the issue that Deven raised covered in your unintended consequences and intended consequences?

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

You know, that's an excellent question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Because there's an inadvertent "forcing" you may have to go somewhere and that may create a compelled consent situation.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

I think, you know, that's an interesting question and we'll go back and have a look at that. I don't think quite the way Deven articulated it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you. Oh, Neil?

Neil Calman – The Institute for Family Health – President and Co-founder

I mean, just, I have a concern about the unintended consequences piece, as I'm sure you all do.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

Yes.

Neil Calman – The Institute for Family Health – President and Co-founder

You know, this is exactly what the press will pick up on, every time there is something negative that comes out about anything it gets 10 times more press than all of the benefits and prospects. I think it's a bad name for a report.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

Yes.

Neil Calman – The Institute for Family Health – President and Co-founder

I think it basically needs to be a report that talks about the benefits of access that could have a final chapter that discusses some of the cautions or as we called them before challenges that need to be faced, but to have a report on the unintended consequences will make the front page of every single newspaper in America and will set us back six months or maybe six years in our efforts to really give people access to their information.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

So, that's a good point and I've actually made that point, it's not officially going to be called the unintended consequences of and I'm afraid I didn't go and look up exactly what the title is, but it's a lot friendlier. It does address, and Jodi you can comment on the larger contract, but I agree with you that the spin and the messaging cannot just be like look at all these negatives.

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

So, we are looking at working on unintended consequences in a lot of areas because we wanted to know, what are the pitfalls that we might get into and how we can mitigate those risks and not just sort of put blinders on and say, well we don't want to do deal with that because we don't want to look at the negative. So, the goal was really to understand what the risks are so that we can mitigate those risks so we can act on them. And so we have this effort in place to do that EHRs, Health IT and we also added patients, the consumer engagement piece.

We talked internally about that very issue, particularly on this one and have talked about also focusing on the benefits, which is not sort of in, you know, kind of within the four, you know, the direct requirements of this project but it's something that we have suggested as, you know, kind of a balancing on this one in particular. So, completely agree with your concern and to the extent that we release something on this we will also make sure that the way it's framed is done well and that approaches to mitigate any potential risks, and these are potential risks not necessarily consequences that we have some strong input and messaging on what are things that can be done or that we will be doing to mitigate risk.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, a corollary to that though is, you know, we talked about the EHR safety report from IOM.

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It wouldn't be unreasonable to have the same kind of reporting and, you know, data aggregation and analysis system in place for consumer access, because we can't, you know, we can't...the more we know the better the outcome will be sort of.

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Right.

Neil Calman – The Institute for Family Health – President and Co-founder

So, just to clarify I'm not against knowing this information or actually even putting in print but I do think it needs to be put...the benefits in this area are less well known to people and if you just put out a document that talks about the problems I think it would be a mistake. So, my suggestion very specifically is to combine it in a document that talks about the benefits and then also articulates some of the things we need to know about.

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Point taken. I think both of us completely agree with that.

Lygeia Ricciardi – Office of Consumer eHealth, Office of the National Coordinator – Acting Director

Yeah, and just so you know we actually expanded the scope of the original project to specifically have the contractors go out and scan for empirical evidence of benefits to bake into that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, that's great. Any other final comments? Thank you for the update and obviously we've learned about some new interesting projects going on. Thanks. So, why don't we open it up to public comment?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Operator, would you please open it for public comment? And if there is anyone in the room who would like to give a comment please come forward to the table.

Alan Merritt – Altarum Institute

If you'd like to make a public comment and you're listening via your computer speakers please dial 1-877-705-6006 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, we'll start with people in the room. Please identify yourself, thank you.

Public Comment

Chantal Worzala – American Hospital Association

Sure, good afternoon. Chantal Worzala, American Hospital Association. What a great conversation on some really forward leaning topics, very exciting of course to realize all of that future progress, we need to make sure we're achieving that wide-spread adoption that's sort of the purpose of the Meaningful Use Program and the EHR incentives, and I know that first thing this morning, a lot has happened since then, Rob presented you with a lot of data and a lot of numbers, and I just want to drill down on the numbers that he presented of the providers who have received a Medicare incentive payment because those are the providers who have actually met Meaningful Use. So, just pulling out those providers we have just over 1000 hospitals that are doing great work who have met Meaningful Use, which is right around 20% of all hospitals.

I did want to highlight however that when you look at subgroups of hospitals much less even progress. So, if you look at the critical access hospitals, we have 1300 critical access hospitals that provide care in remote and rural areas, and we have about 9% of critical access hospitals that have met Meaningful Use. And it's actually very important to know that number because the way the law is written Meaningful Use incentives have a very short fuse and so in fact for critical access hospitals they have to meet Meaningful Use by September 30th of this calendar year in order, in other words 2 months from now essentially, in order to benefit fully from the Medicare incentive program.

So, it seems pretty clear, you know, even if we double the number of critical access hospitals that get to Meaningful Use by the end of this fiscal year, which is September 30th, that will only be 20% of critical access hospitals that benefit fully from the Medicare EHR incentive program which obviously means that 80% will not.

So, as we think about what are the supports that providers need and, you know, is adoption fast enough to get us where we all want to go I think that's an important number to keep in mind. So, I would also just highlight that for physicians on the Medicare side, they, too, have to meet Meaningful Use this year in order to benefit fully from the Medicare incentive program and after that the amount of incentive that they can receive is reduced. So, just wanted to make sure, I know there were a lot of numbers flying around, but those are sort of the ones that we look at as telling us, you know, how wide-spread is the adoption that we are achieving right now.

I really want to thank folks for having the quality hearing and the very robust discussion about quality reporting through EHRs at this table. And I want to put that in a little bit of context. If you look across the Medicare Program a hospital submits more than 90, Nine-Zero, quality measures to CMS and if you look across all of the payers, many hospitals are generating hundreds of quality measures and what we really need to do and I think there is a lot of work along this line, but we might need to accelerate the pace to really focus in on that narrow set and make sure that we can leverage the efficiency of automated reporting to really get a small set of valid, reliable and feasible quality measures that we can build up from.

I think that for hospitals, at least, that we set in Meaningful Use Stage 1, that's a pretty good set of measures, they're good measures, but we're not yet at a point frankly where we can sort of hit that magic F7 key and get the data out. So, really focusing first on getting those measures to be valid, reliable and feasible would be a great first step thanks so much.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you. I believe we have one person on the phone with a comment?

Alan Merritt- Altarum Institute

Yes, Shelly Spiro, please proceed with your comment.

Shelly Spiro - Pharmacy e-Health Information Technology Collaborative - Director

Thank you, my name is Shelly Spiro, I'm the Director of the Pharmacy e-HIT Collaborative representing over 250,000 individuals as members of the majority of the National Pharmacy Association and key pharmacy organizations involved in health information technology. In Jodi Daniels presentation today she mentioned engaging non-eligible providers in the Meaningful Use of the electronic health record. The Pharmacy HIT Collaborative participated in the prescription drug monitoring program Workgroup activities mentioned by Jodi.

In addition, Collaborative members participate in the long-term, post-acute care and behavioral health initiative providing medication related expertise for these practice settings and we work very closely with some of the presentations that those have presented during today's hearing. Pharmacist play an integral role in the interprofessional healthcare team in providing medication related patient care services outside and in conjunction with prescription dispensing functions.

Similar to the long-term HIT collaborative roadmap document presented earlier by Larry Wolf, the pharmacy industry has a roadmap too and we would be glad to provide that to the members of the HIT Policy Committee. This roadmap outlines the goals, objectives and strategies for pharmacist to adopt and implement Meaningful Use of the electronic health record.

Late last year, the United States Public Health Service released a report delineating the mechanisms to optimize the role of pharmacists in the healthcare team. This report received support from the US Surgeon General, Dr. Regina Benjamin, and also provides the evidence policy makers need to support the utilization of pharmacist as an essential part of the healthcare team.

Pharmacists are trained through their access to patients and are in a unique position to assist in engaging patients in their healthcare. Pharmacists are one of the largest providers of immunizations across the United States and in addition pharmacist's involvement in medication related coordination, such as medication therapy management can provide significant patient care quality improvement.

The Collaborative hopes that the HIT Policy Committee and the Office of the National Coordinator will agree engagement of pharmacists as non-eligible providers of the Meaningful Use of the electronic health record will improve patient care and help other eligible professionals meet their Meaningful Use incentives. Thank you.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much. Do we have any other comments?

Alan Merritt- Altarum Institute

We have no further comments at this time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you everyone. Since this was a largely informational meeting I think you...hopefully you'll recognize that this was the summer break, that was it. Next month we will go back to deliberating recommendations.

Deven McGraw – Center for Democracy & Technology – Director

That starts tomorrow at the hearing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, that starts tomorrow at the hearing and the results will be presented next month, in just three weeks. So, anyway, thank you and enjoy the rest of your summer

Public Comment Received During the Meeting

1. Have heard that 10% of the EPs and hospitals who have received incentive funds will be audited - can you confirm?
2. I'd like to know which vendors the RECs are using and how they were selected. Is this information published and if yes, where might I find this information? Having access to the successes and failures would be very informative. Thank you.
3. A vendor selection tool was just mentioned. Please make this information publicly available.
4. Have the committee members discussed the storage, retrieval and presentation issues that may be involved with the volumes of data that may be imported from all the patient home monitoring devices? Who pays for the storage, the doctor/clinic or hospital? Thanks.